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**PHYSICIAN PAYMENT REFORM AND THE
IMPLEMENTATION OF THE MEDICARE FEE
SCHEDULE: AN INSTITUTIONAL AND
RESOURCE DEPENDENCY PERSPECTIVE**

by

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December, 1995

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RESOURCE DEPENDENCY PERSPECTIVE**

by

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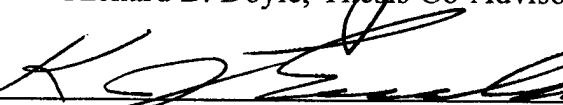


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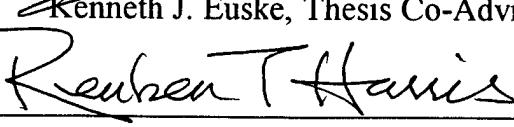
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ABSTRACT

The purpose of this thesis was to gain an understanding of the formation and implementation of the objectives of the Medicare Fee Schedule as set forth in the Omnibus Budget Reconciliation Acts of 1989 and 1990.

The research for this thesis was approached by employing the methodology suggested by the institutional and resource dependency theories of organizational behavior. Archival research was the primary technique used to obtain data describing behavioral and fiscal trends associated with Medicare Part B and the Medicare Fee Schedule. Analytic and empirical research techniques were also applied to facilitate identification of organizations active in the reform environment. Research findings were used to construct the model of the Department of Health and Human Services organizational environment on which the analysis was based.

Findings include: a) a fragmented pre-reform organizational environment, b) general consensus regarding the concept of physician payment reform among the Department of Health and Human Services and organizations active in the environment, c) disagreement and coalition building in the organizational environment in response to the Department of Health and Human Services proposed rule and d) effective pressure group politics by special interest groups in gaining the congressional support needed to convince the reform administrator to engage in major payment reform rule revisions.

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I. INTRODUCTION

A. OVERVIEW

1. Objective

This thesis examines the objectives of the Medicare Fee Schedule (MFS) as set forth in the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) and amended by the Omnibus Reconciliation Act of 1990 (OBRA 90) and the incentive structure created to achieve those objectives. In addition to a review of quantitative measures of program performance, this work also considers program objectives and achievements from the perspectives of institutional (Scott, 1987, pp. 493-511) and resource dependency (Pfeffer and Salancik, 1978) theories of organizations.

2. Methodology

With the intent of putting the changes effected by these Acts into historical context, this chapter includes a brief examination of the organizational environment preceding Medicare physician payment reform. Following this discussion of the pre-reform environment, Chapter II presents an introduction to the salient features of the physician payment reform. It focuses on program mechanisms incorporated in the Omnibus Budget Reconciliation Act of 1989 and the Omnibus Budget Reconciliation Act of 1990. The three major mechanisms of physician payment reform and their key subcomponents are presented within the context of their intended effect. Interrelationships between the mechanisms are identified and the significance of the interdependencies addressed.

The scope of the examination is narrowed in Chapter III so that the Medicare Fee Schedule (MFS), the manner in which the fee schedule is influenced by Medicare Volume Performance Standards (MVPS), and the effects of political influence may be considered from an organizational control system perspective. Models are developed to gain an understanding of the manner in which the effects of major actors, the environment, and the administrative control mechanisms required by legislation and regulation interacted to influence change in the structure of the medical industry.

Chapter IV considers the Department of Health and Human Services (DHHS) environment. Organizations active in the physician payment reform process are identified and a model of the organizational environment is constructed.

In Chapter V, selected changes to the program prior to the implementation of physician payment reform in 1992 are analyzed using the framework provided by the organizational behavior models. Emphasis is placed on the reaction of the environment to the details promulgated in the Notice of Proposed Rule Making (NPRM) published by the Department of Health and Human Services (DHHS) on June 5, 1991.

Finally, Chapter VI summarizes significant program events and compares events relative to the outcomes suggested by the models presented in Chapter IV. Anticipated and unanticipated outcomes are examined and conclusions drawn concerning the utility of institutional and resource dependency models as tools for analyzing physician payment reform.

B. THE MEDICARE ENVIRONMENT, 1965-1989

In order to understand the significance of the physician payment reform effort and the manner in which it was executed, it is necessary to examine the environment that prompted its undertaking. Program history, scope, and operational performance measures are used to establish the setting in which reform took place.

1. Enactment of the Medicare Program

The Medicare Program, embodied in Public Law 89-97, was signed into law on July 30, 1965 by President Lyndon Johnson. Implemented on July 1, 1966, it was originally intended to increase access to health care for the nation's elderly, primarily by providing a degree of financial relief from the burden of the cost of care. The organizational structure that was adopted to achieve this objective divided program administration into two major subdivisions, Medicare Part A and Medicare Part B.

2. Major Medicare Components

a. Medicare Part A

Medicare Part A, the Hospital Insurance (HI) program, was intended to cover those services provided by hospitals, skilled nursing facilities (SNF) and some care provided by home health agencies. A Hospital Insurance (HI) Trust Fund was established and funded by: a) payroll taxes, b) transfers from the Railroad Retirement Account, c) transfers from Railroad Uninsured Persons, d) reimbursement for voluntary enrollees, e) payments for military wage credits and f) interest on trust fund investments. Historically, the dominant source of income for the Hospital Insurance (HI) Trust Fund has been the payroll tax. Beginning with the introduction of the program in 1967, the portion of income contributed

by payroll taxes has remained relatively steady at approximately 90 percent of all program revenue. A summary of total trust fund revenue levels is provided in Figure 1.

Because the Hospital Insurance (HI) Trust Fund receives no payments from the Treasury general fund, it must consider the balance between program disbursements and income as it provides its services. It is a result of these accounting mechanisms that makes it possible to talk about the concept of Hospital Insurance (HI) Trust Fund positive balances and bankruptcy.

b. Medicare Part B

Medicare Part B, also known as the Supplemental Medical Insurance (SMI) program, was intended as a complement to the Hospital Insurance program. Part B addresses the provision of physician services for ambulatory care, durable medical equipment (DME), and limited home health agency care. There are three sources of funding for Medicare Part B: a) insurance premiums paid by program participants, b) interest and other income and c) government contributions from the general fund.

Insurance premiums, originally intended in 1967 to cover 50 percent of Part B costs, currently provide for approximately 25 percent of program requirements. Specifically, in 1992 premiums amounted to \$12,748 million, which was approximately 23.99 percent of total Supplementary Medical Insurance (SMI) Trust Fund income (Health Care Financing Administration, 1994, p. 35). Unless otherwise noted, all monetary values are presented in nominal dollars. Interest and other income is described by the Health Care Financing Administration (HCFA) as consisting of recoveries of amounts borrowed from the trust fund "which are not obligations of the trust fund and other miscellaneous income"

(Health Care Financing Administration, 1994, p. 35). In 1992 this source comprised approximately 3.23 percent of trust fund revenue. The third and final source of trust fund income is received from government contributions. This source provides the balance of funding required to support the Supplementary Medical Insurance (SMI) program. In 1992 government contributions amounted to \$38,684 million which constitutes approximately 74.97 percent of program requirements (Health Care Financing Administration, 1994, p. 35). A summary of Supplementary Medical Insurance (SMI) income by revenue category is provided in Figure 2.

Unlike the Hospital Insurance (HI) Trust Fund, the Supplementary Medical Insurance (SMI) Trust Fund does have a direct channel to the Treasury general fund. By design, it is this income channel from the Treasury that covers the cost of care not provided by participant premiums, deductibles and program investments. Because of this revenue structure, the Supplementary Medical Insurance (SMI) Trust Fund does not face the bankruptcy issues currently being contemplated by the Hospital Insurance (HI) Trust Fund trustees. However, the concepts of surplus and deficit spending still can be used when evaluating its financial performance.

3. Trends Affecting Medicare Part B

The trends and some of the external pressures that program administrators were being subjected to during this period are discussed below to provide a more complete description of the environment in which these decision makers were functioning prior to the initiation of reform.

a. Recognition of the Need to Act

During the late sixties and early seventies, the relatively greater volume of expenditures and rapid growth taking place in Medicare Part A may have caused it to take precedence over concern for the events and trends that were transpiring in Part B. As seen in Figure 3, in terms of outlays Part A was and remains a much larger program than Part B, which may explain why Part A was subject to more immediate attention and review. Also, the enrollment in Medicare Part A and Part B have remained approximately the same even though the expenditures for Part A have increased more rapidly than the expenditures for Part B. For example, in 1975 the number of Hospital Insurance (HI) enrollees totaled 24.6 million, while for the same period Supplementary Medical Insurance (SMI) enrollment totaled 23.9 million, a difference of only 2.85 percent. As indicated by the level of legislative activity, even though during this period some controls on the growth in expenditures for physician services in Part B were attempted in 1971 by the Nixon administration, the majority of attention remained fixed on Part A.

A source for reform of Part A was the Social Security Amendments of 1983 (Public Law 98-21). As a result of these amendments Medicare changed the way hospitals were paid for their services. Before the amendments were enacted, under the traditional "reasonable cost basis," there were no effective mechanisms in place for controlling the volume or intensity of care. The retrospective fashion in which hospitals were being reimbursed seemed to encourage less than optimal utilization of resources when treating a patient. (Congressional Budget Office, 1986, p. xv) This methodology provided an incentive for conservative practices such as redundant laboratory testing, over testing in order to

minimize liability, and prolonged admission periods. The results of practices of this nature were higher overall costs. (Moon, 1986, p. 331)

The reasonable cost basis approach was replaced by the Prospective Payment System (PPS), beginning October 10, 1983. Under the Prospective Payment System (PPS) hospitals were compensated using rates that were determined in advance of treatment. Specifically, a fixed amount per case was paid based upon the type of case or "diagnosis-related group (DRG) into which the case was classified"(Ways and Means Committee of the House of Representatives, U.S. Congress [henceforth, Ways and Means], 1994, p. 131). Under the Prospective Payment System (PPS), the more cost effective a hospital became and the lower its rates fell below the Prospective Payment System (PPS) predetermined allowable cost, the greater its profit margin.

The incentive to increase profits by increasing efficiency appears to have been communicated to hospital administrators, and in general the Prospective Payment System (PPS) was viewed as a success by program administrators. (Moon, 1993, p. 60) Success, in this context, was measured "not in absolute dollars, but in terms of what Medicare would otherwise have had to pay for care"(Moon, 1993, p. 60). Apparently convinced that the Prospective Payment System (PPS) was having the desired effect, attention began to shift to the next most significant demand on Medicare resources, Medicare Part B, specifically the rate of growth in physician payments.

b. A Change in Emphasis to SMI

As demonstrated in Figure 4, during the late seventies and early eighties, the average annual growth rate was actually larger for Part B physician services than for Part A

inpatient hospital services. Specifically, during the interval 1975 through 1985, benefit payments for physician services increased at an average annual growth rate of 18.5 percent compared to 16.3 percent for inpatient hospital services. (Ways and Means, 1994, p. 125)

This difference in program growth rates attracted the attention of political leaders and administrators to the rising cost of physician services. (Epstein, 1993, p. 193) Studies and hearings regarding Part B outlays and efficiency followed. The Congressional Budget Office in their 1986 publication, *Physician Reimbursement Under Medicare: Options for Change*, indicated that as review of the program progressed, policy makers and others became concerned that payment levels for services were becoming increasingly unrelated to the costs or medical value of the services (Congressional Budget Office, 1986, p. 26). Their concern appears to have stemmed in part from the perception that physician fee differentials under pre-Medicare Fee Schedule (MFS) methodology and by type of service "were creating financial incentives for unnecessary tests or for surgical and other procedural care over cognitive care, such as history-taking and discussion of methods by which patients might prevent or alleviate their own symptoms (Congressional Budget Office, 1986, p. 31). Other sources of general dissatisfaction with the payment methodology of the time include a belief that the methodology encouraged "increases in both the price and the volume of services" and "overspecialization by physicians"(Congressional Budget Office, 1986, p. 26). As suggested by Moon (1993), this seems to have evolved into the perception that the existing payment methodology, (Customary, Prevailing and Reasonable (CPR)), provided a system that perpetuated inappropriate economic incentives regarding the value of services that were being provided. There was concern that the program was

...paying relatively more for expensive, high-technology services while offering few incentives for careful geriatric assessments or other basic care (Moon, 1993, p. 65).

Concepts such as an “overvalued” and “undervalued procedures” began to appear in legislation and literature at approximately this time. References to overvalued procedures were generally associated with technology intensive services such as surgery. (Congressional Budget Office, 1986) In contrast references to undervalued procedures were identified with preventative care and services provided by family physicians and general practitioners. (Congressional Budget Office, 1986)

DeLew et al. (1992) has indicated that these concerns were tied to the general perception that the health care system in the U.S. suffered

...from rapid escalation of health costs, lack of universal access to insurance coverage, geographic maldistribution of providers, underutilization of primary care and preventive services, gaps in the continuity of care, and a high rate of inappropriate utilization of health services (DeLew, et al., 1992, pp. 158-159).

This view was underscored in the Physician Payment Review Commission’s (PPRC) June 16, 1989 statement before the Subcommittee on Health and Long Term Care. The Commission indicated that there was “increasing evidence that beneficiaries were receiving some services that were considered unnecessary and failed to receive some services that would benefit them” (Eisenberg, 1989, p. 7). The Physician Payment Review Commission (PPRC) was concerned that this trend was contributing to lower quality care at a greater cost. (Eisenberg, 1989, p. 7)

Also related to the growing outlay rate for Medicare Part B was the effect existing incentive structures were having on physician populations. Specifically, it was “suggested that the growing number of physicians was a cause of rising medical expenditures and that reducing the number of physicians per 1000 people would help to contain costs” (Congressional Budget Office, 1995, p. 32).

At the same time program strengths were also being recognized. These strengths included

...providing the vast majority of the population with state-of-the-art care, offering consumers freedom of choice among a variety of highly skilled providers using the latest technology, promoting a vigorous biomedical research and development sector, sophisticated quality assurance and data systems and virtually no queues for elective surgery for those with insurance(DeLew, et al., 1992, pp. 158-159).

c. The Medical Industry and Medicare

During this period, growth in health care costs in the medical industry as a whole was being associated with

...the predominant fee-for-service payment system, extensive third-party insurance coverage, a fragmented multipayer system, and a vigorous biomedical research establishment combined with rapid diffusion of new technologies (DeLew, et al., 1992, p. 159).

Although influenced by these industry-wide influences, the growth in Medicare Part B expenditures was attributed to more specific factors.

Explanations for growth in Part B expenditures included a combination of the following factors: a) the expansion of Medicare coverage in 1973 to include the disabled and the subsequent growth in the number of enrolled persons with end-stage renal disease (ESRD), b) growth in the use and scope of Supplementary Medical Insurance (SMI) outpatient services, c) the implementation of Prospective Payment System (PPS), which provides financial incentives for eliminating or reducing Hospital Insurance (HI) inpatient hospital care and channeling appropriate types of care to Supplementary Medical Insurance (SMI) ambulatory settings, d) growth in the number of physicians participating in the Medicare program, e) the increased scope, complexity, and cost of physician services and f) the changing demographic makeup of the enrolled Medicare population (Health Care Financing Administration, 1992, p. 26).

d. Causes of Growth: Enrollment and Utilization

Medicare Part B benefit payments being drawn from the general fund was increasing (see Figure 2). A portion of this expenditure growth may attributed to an increase in program enrollment. Depicted in Figure 5 is a trend of Supplementary Medical Insurance (SMI) enrollment statistics that shows an increase from a level of 23,339,000 persons in 1975 to approximately 32,333,000 persons in 1990. The rate of growth for enrollment during this period was approximately 38 percent.

Figure 6 demonstrates that benefit payments per enrollee were also growing during this period. Benefit payments per beneficiary grew from an average level of \$161 per enrollee in 1975 to and average of \$1282 per enrollee in 1990. During the same period when Supplementary Medical Insurance (SMI) enrollment growth had increased by 38 percent,

average payments per beneficiary had grown by approximately 696 percent, more than eighteen times more rapidly.

It should be noted that not all enrollment growth during this period is attributable to the aged. In the early seventies there occurred an event that "substantially increased the commitments of all aspects" (Moon, 1993, p. 31) of the Medicare program. Legislation was passed extending Medicare coverage to disabled persons and to individuals with end-stage renal disease (ESRD). The effect of this policy was that the two affected groups

...added to Medicare's rolls resulted in an instant expansion of 10 percent in the number of beneficiaries and an even larger boost to the costs of the program, since disabled persons tended to be more expensive to cover than the elderly, on average (Moon, 1993, p. 32).

The impact on the average annual benefit per person enrolled in Part B resulting from resulting from the provision of coverage to disabled beneficiaries and those with end-stage renal disease (ESRD) is readily observable in Figure 7. Specifically, Figure 7 demonstrates the impact that the average Supplementary Medical Insurance (SMI) benefit received by disabled beneficiaries has on the average total benefit received by all recipients.

These trends indicate that, increased enrollment and utilization contributed to growth in program costs. Health Care Financing Administration projections indicate that these trends will continue and show no signs of abating in the near future. (Health Care Financing Administration, 1994) The data presented next indicates that revenue stream policy decisions,

population demographics and economic conditions may also have contributed to Supplementary Medical Insurance (SMI) cost growth.

e. Revenue Stream Status and Policies

While demands on the general fund to support Medicare Part B were increasing, those being made on Supplementary Medical Insurance (SMI) enrollees remained relatively constant. Relative to economic conditions during this period, policies that determined the levels for the Supplementary Medical Insurance (SMI) deductibles and premium levels may have contributed to cost growth.

As shown in Figure 8, the level at which the Supplementary Medical Insurance (SMI) deductible was established had changed only once over the period 1966-1990 and then only by a total of \$25. Simultaneously, as shown in Figure 9, the Medical Consumer Price Index, a measure of the amount of inflation in medical costs, grew at a greater rate than the total consumer price index for the period.

An effect caused by holding the Supplementary Medical Insurance (SMI) deductible rates at a relatively low level while the medical industry was experiencing relatively significant inflation was a constant erosion in the purchasing power of the deductible portion of Supplementary Medical Insurance (SMI). As a result, enrollees were likely to exhaust their deductible and make claims against Part B at a rate that increased with the passage of time. "By 1991, more than 80 percent of all Medicare enrollees exceeded the deductible amount, compared to 52 percent in 1975" (Moon, 1993, p. 45). Normalized data provided by the Health Care Financing Administration (HCFA) in their February 1995 *Medicare and Medicaid Statistical Supplement* further support this effect. Specifically, "in 1967, an

estimated 7.2 million Medicare beneficiaries used covered services, an annual rate of 366 persons served per 1,000 enrollees. By 1992, an estimated 27.9 million beneficiaries used covered Medicare services, an annual rate of 785 persons served per 1,000 enrollees, or more than 2.1 times higher than the rate in 1967". (Health Care Financing Administration, 1992, p. 26)

Simultaneously, the purchasing power of the Medicare Part B premium relative to program expenditures was also declining. As demonstrated in Figure 10, since program introduction, the portion of benefit payments as compared to premium income has remained in excess of its 1967 level of 1.0. This indicates that in order to meet required program expenditures, an increasingly larger portion of the payment for physician services was being made up of revenue from the general fund. For example, the 1990 ratio was constructed by dividing the total benefit payments of \$41,498 million by \$11,494 million, the total premium income from program participants, for a ratio of 3.6.

f. Program Outlays and the Cost Sharing Burden

From the program's inception, the government's share of the Medicare Part B benefit payments has grown. As indicated in Figure 10, the ratio of benefit payment to premium income has increased from a value of 1.0, or a 100 percent share for beneficiaries in 1967 to a level of 3.5, or approximately a 72 percent share for the government in 1989. Note that during this period the ratio reached a level as high as 4.6. Specifically, in 1987 as the need for physician reform was being considered, the government was paying out \$4.60 for every \$1.00 received from program participants or an equivalent share of approximately 80 percent.(Health Care Financing Administration, 1994, p. 38)

Similarly, program outlays also grew during this period. Figure 11 provides outlays for the period. Figure 12 provides outlays as a percent increase over the previous year. While Figure 4 demonstrates past and projected outlay growth rates in Part A and Part B, Figure 13 indicates that beginning in 2010, a point beyond the projections provided in the aforementioned figures, outlay rates are likely to grow even more. A comparison of Medicare Part B program income relative to outlays (total disbursements) for selected periods is provided in Figure 14. Figure 14 indicates that through 1993 income exceeded outlays. As mentioned previously, Medicare Part B total income is defined as the sum of three components: a) premiums from participants, b) interest and other income, and c) government contributions. Total disbursements are comprised of two components: a) benefit payments and b) administrative expenses. The financial status of the Supplementary Medical Insurance (SMI) Trust Fund is dependent upon the "total net assets and the liabilities of the program" (Health Care Financing Administration, 1994, p. 35) and may be calculated by first summing total program income for the current year with the trust fund balance from the prior year and subtracting current year disbursements.

g. Impact of the Price of Physician Services

Growth in the price of physician services also had an impact on program costs. This phenomenon becomes evident by considering the ratio of physician income to opportunity costs for physicians over the history of the Medicare program. This performance measure provides an indication of a physician's income relative to the income an individual would be likely to be earning had they pursued the career of a "typical college graduate". Data gathered by the Congressional Budget Office (CBO) indicates that the value for this

ratio was approximately 1.25 just prior to the introduction of Medicare. In 1971 the ratio had risen to a peak value of approximately 1.5. It has maintained an average value of approximately 1.35 throughout the eighties. The Congressional Budget Office (CBO) has indicated that program payment incentives initiated the cycle of attracting physicians and increasing program costs. (Congressional Budget Office, 1995, pp. 26-27) Specifically, "the historical evidence is consistent with the view that the introduction of those government insurance programs brought about a surge in demand for physicians' services ... which in turn... "led to an increase in physicians' income" (Congressional Budget Office, 1995, p. 26).

Furthermore, Moon notes that the per enrollee Supplementary Medical Insurance (SMI) benefit payments adjusted for inflation in the medical industry grew by nearly 100 percent over the period 1975-1990. (Moon, 1993, p. 46). Various price control strategies were tried throughout this period in an attempt to reduce physician price growth. One of the most notable measures imposed a freeze on the reimbursement rates to physicians. In FY 1984 rates were frozen at FY 1983 levels with a projected savings of \$700 million (Bureau of National Affairs, 1983, p. Y-1). At the end of FY 1984 Congress extended the freeze an additional year with the anticipation of saving \$600 million in FY 1985 (Bureau of National Affairs, 1984, p. D13).

Freezes in physician payment rates as growth control measures for physician payment were unlikely to be tolerated indefinitely. After the two-year freeze, indexing of physician payment rates resumed. Specifically, the 1976 implementation of the Social Security Amendments of 1972 required that updates for prevailing charges for physicians not exceed the Medicare Economic Index (MEI). Analogous to the Medical consumer price

index, the Medicare Economic Index (MEI) was intended to serve as "a proxy for measuring changes in physicians' practice costs and earnings.(Levy, et al., 1992, p. NS85). As such, beginning in FY1986, growth rates were once again determined by the Medicare Economic Index (MEI). This mechanism for controlling growth was employed in this form until the implementation of the Omnibus Budget Reconciliation Act (OBRA) 1989 and Omnibus Budget Reconciliation Act (OBRA) 1990 physician reform measures.

Although one possible response from physicians to the implementation of the payment freeze may have been to see fewer Medicare patients, the statistics from the period do not support that behavior. As depicted in Figure 15, the volume of Supplementary Medical Insurance (SMI) beneficiaries receiving reimbursed services continued to increase throughout the eighties. One could interpret the data as indicating that Medicare, responsible for approximately 25 percent of personal health care expenditures, was able to achieve minor savings during this period, in part, because the market for physician services had a relatively low price elasticity of supply. Specifically, during the freeze instead of refusing to provide services to Medicare Part B patients physicians behaved as price takers.

h. Indirect Effects of Medicare Part A

The Prospective Payment System (PPS) for Medicare Part A is also credited with increasing Part B expenditures.(Health Care Financing Administration, 1992, p. 26) This effect is a result of hospital and physician responses to the Prospective Payment System (PPS) incentives and technological advances that appear to have encouraged the accelerated restructuring of a number of care procedures. As a result of Prospective Payment System (PPS) implementation, many procedures traditionally performed on an inpatient basis were

converted to and performed as outpatient procedures. Consequently, hospital outpatient procedures grew faster than any other service provided by Medicare. In 1992, "the thirty-one-fold increase in hospital outpatient payments since 1974 far exceeds the elevenfold increase in overall Medicare payments and the ninefold increase in overall hospital payments by Medicare" (Health Care Financing Administration, 1992, p. 96). During this period, hospital outpatient services, which are paid for primarily by Medicare Part B, "comprised 8.2 percent of total Medicare payments in 1992, compared with 2.9 percent in 1974" (Health Care Financing Administration, 1992, p. 98).

Other examples of behaviors prompted by Prospective Payment System (PPS) include lab work in support of inpatient procedures being conducted prior to admission, after discharge or both. (Moon, 1986, pp. 331-332) In addition to technological advances, hospitals responded to the constraints presented by the DRG-driven reimbursement rates by seeking a more cost effective manner in which to provide care. By providing care in a hospital outpatient setting, physicians were able to provide a service similar to that previously provided, while receiving reimbursement from Medicare under the relatively more generous Current, Prevailing and Reasonable (CPR) payment methodology, avoiding Prospective Payment System (PPS) constraints. (Health Care Financing Administration, 1992, p. 26)

i. Increase in Physicians Electing to "Participate"

Increased physician participation in the Medicare program is also credited with contributing to expenditure growth. Since the enactment of the Medicare Program in 1965, a number of successful policies were created that successfully encouraged both physicians and

beneficiaries to participate in the program. Of the more prominent and readily observable policies were those pertaining to physician payment methodology and administrative oversight. Initial payment levels are described as having been relatively generous and the professional environment such that "doctors were promised no restrictions as to the care they could provide".(Moon, 1993, p. 64)

For the first 25 years of the Medicare program the physician response was consistent with policy incentives. As illustrated in Figure 16, in the absence of any significant physician payment reform efforts during the first quarter century of the program, the percentage of physicians participating in Medicare has grown steadily. As illustrated in Figures 16 and 17, physician populations in general and Medicare participating physicians in particular grew throughout the 1980s and levels are expected to continue to grow into the foreseeable future. (Congressional Budget Office, 1995, pp. 26-27)

Consistent with the growth in the ratio of physician income to the opportunity cost associated with not being a physician is the trend in active physicians per 10,000 population. As Figure 18 demonstrates, in 1970 there was an average of only 15.6 physicians per 10,000 population. By 1991 that number had increased to an average of 24.2 per 10,000 and it is projected to reach 27.7 by the year 2010. This trend may be of particular concern because even if there is a surplus in the number of physicians, physicians may be able to "create demand and thereby add to rising health costs"(Rice, et al., 1989, pp. 587-600).

j. Physician Population Composition

During the eighties, policy makers argued that the Current, Prevailing and Reasonable (CPR) payment methodology locked in historical inequities with regard to

treatment incentives. Specifically, policy makers indicated that major inequities were being perpetuated because, "the CPR methodology 'overpays' technical procedures like surgery and 'underpays' other services such as office visits" (Lee, 1994, p. 65). Consequently, while throughout the seventies and eighties physician populations increased, the specialties enjoyed the greater share of the revenue growth. This in turn argued the policy makers, fostered a more rapid growth in specialties than in general practitioners. (Congressional Budget Office, 1986, pp. xvii-xix)

The distribution of physicians by specialty was believed to have contributed to high program expenditures. (Department of Health and Human Services, 1991, p. 109) Because of their additional training and high rates, services provided by specialists were perceived to be of greater value than generalists. Beneficiaries, seeking to receive the best available care and benefiting from Part B subsidies, tended to seek specialist treatment. For example, in 1984 primary care providers, consisting of general practitioners, family practitioners and doctors of internal medicine, received approximately 34.7 percent of the amounts allowed for physician services. Surgical specialists, which include general surgery, otolaryngology, neurosurgery, gynecology, ophthalmology, orthopedic surgery, plastic surgery, colon and rectal surgery, thoracic surgery, and urology, claimed approximately 36.2 percent of Part B allowed amounts. The remainder of payments was distributed to nonsurgical specialists (14.3 percent), radiologists (8.4 percent), anesthesiologists (4.8 percent), pathologists (0.9 percent) and osteopaths (0.7 percent). (Congressional Budget Office, 1986, p. 17)

The Current, Prevailing and Reasonable (CPR) payment methodology was also credited with providing relatively low payment incentives for rural practitioners. Note that of the physicians that were in active practice in rural areas in 1988, "about 33 percent were primary care physicians (family practice, general pediatrics, and internal medicine) and the remainder was specialists" (Politzer, et al., 1991, pp. 104-109). In addition to evidence that indicates the rural practitioners were paid less than their urban counterparts, there was a general inconsistency in the geographic distribution of payment rates. Payments for hip replacements in 1984 provide an example of this phenomenon. For example, in 1984 "the prevailing charge for total hip replacement in Washington, D.C., was \$1,547, compared with \$4,126 in New York City" (Epstein, et al., 1993, p. 193).

To reduce costs caused by these inequities, decision makers were confronted with two challenges: 1) the creation of an incentive structure that would encourage a migration from the relatively higher paying specialties to fill the perceived void in primary care providers and 2) to correct a perceived access problem by creating incentives that would result in a migration from an industry with predominantly urban practices to one that provided for needs in rural areas. (Epstein, et. Al, 1993, p. 193)

k. Physician Services: Scope, Complexity and Cost

The increased scope, complexity, and cost of physician services as well as increases in the volume of services provided per beneficiary may also have contributed to increases in the real cost of health care. Changes in scope and complexity imply an aggregate change in the intensity of care. (Danzon, 1993, pp.677-683) "Intensity reflects changing

technology, quality, and other factors that make any given service, such as a diagnostic test, more resource-intensive than it was in the past" (Danzon, 1993, p. 677-683).

From an economic perspective, the subsidy provided by Medicare tends to distort the marginal cost/marginal benefit relationship when considering whether or not to use new technology in the treatment of an illness. A practice consistent with the incentives provided by subsidized care is for the physicians to compare the marginal benefit of a new technology to the cost to the beneficiary and not to the total cost of the treatment. Specifically, the total cost of the treatment is the amount billed to the beneficiary plus that billed to the insurer. In the case of Medicare Part B, decisions regarding the use of new technologies for beneficiary treatment under the Current, Prevailing and Reasonable (CPR) methodology were often being based on a cost that was approximately 25 percent of that actually being incurred. (Danzon, 1993) As suggested by Danzon, the bottom line is that "technology appears to be the single most important factor driving health care costs currently"(Danzon, 1993, p. 679).

l. Beneficiary Demographics

Changing demographics have also been credited with contributing to the growth of Part B expenditures. "In 1992, the 85 years of age or over group represented 9.9 percent of the total enrolled population, compared with only 8.1 percent in 1978" (Health Care Financing Administration, 1992, p. 26). Longer life spans imply longer periods of program eligibility for recipients and consequently greater demands on program resources. As demonstrated in Figures 19 and 20, the steady gradual increase in life expectancy at birth

and at age 65 indicates that the population in the United States, enhanced by the forthcoming arrival of the "baby boomers," will continue to grow older.

m. Intensity of Physician Services

The role played by cost/ benefit measures as a decision variable for assessing the appropriate level of care intensity also appears to have been a significant consideration during the pre-reform period. The importance of this variable was stressed by Danzon when she suggested that "massive government subsidies . . . cause medical providers to use technology that consumers may value less than the (actual) cost"(Danzon, 1993, p. 679). An observation of economic inefficiency, this statement begs the question of applying appropriate performance measures to gauge the effectiveness of resource allocation and suggests that price be used as the discriminator.

At present no single performance measure is accepted to gauge medical program performance. As illustrated in Figure 21, a progressively increasing share of the Gross Domestic Product (GDP) has been and continues to be devoted to health care. One possible measure of program performance uses life expectancy and mortality rates as a measure of return on the national investment. As a measure of program success these statistics are not very encouraging. Even though the United States commits more economic resources to health care than any other nation it is still ranked 17th in male life expectancy, 16th in female life expectancy, and 20th in infant mortality. (Schieber, et al., 1991, pp. 22-38).

It can be argued that the U.S. life expectancy and mortality statistics are misleading and, that relative to other developed countries, more intense social problems in the United States such as violent crime may be credited with deflating the overall performance

of the medical industry. (DeLew, et al., 1992, p. 157) Because of this and similar trends, ambiguity continues to exist. Regardless, there does not seem to be a consensus as to what constitutes an appropriate set of performance measures for determining the effectiveness of the investment in health care services for the nation. Without an accepted set of performance and economic measures, optimum resource allocation is difficult to identify. (Danzon, 1993, p. 677)

C. RESPONSE TO THE ENVIRONMENT

Although many complex and interrelated factors have contributed to Supplementary Medical Insurance (SMI) cost growth, the data that has been presented suggests that decision makers have targeted three desired outcomes from physician payment reform as prescribed in the Omnibus Budget Reconciliation Acts of 1989 and 1990. (Levy, et al., 1992, p. NS80) First, through the Medicare Fee Schedule (MFS) they attempted to realign the incentive structure for physicians. By realigning payment incentives it appears that decision makers sought: 1) to eliminate geographical payment inequities locked-in by the Current, Prevailing, or Reasonable payment methodology, 2) to improve access to care for beneficiaries in rural areas, and 3) to eliminate distortions in payments caused by procedures that were perceived to be "overvalued." (Department of Health and Human Services, 1991, pp. 1-179)

Second, the Medicare Volume Performance Standard (MVPS) was implemented to control the rate at which program costs would be allowed to increase. In this case it appears that decision makers sought to impose some responsibility on the medical industry for controlling cost growth by modifying the mechanism used to govern the growth in payment rates. Specifically, by adding an adjustment factor to the Medicare Economic Index (MEI)

it seems that decision makers attempted to motivate medical professional organizations to monitor and influence the behaviors of physicians. (Rice, et al., 1990, p. 295)

Finally, using the maximum allowable actual charge (MAAC), it appears that decision makers sought to protect beneficiaries from increased burdens that may have resulted as an outcome of Medicare Fee Schedule (MFS) and Medicare Volume Performance Standard (MVPS). (Levy, et al., 1992, p. NS80) In particular, it appears that there was concern that physicians might respond to Medicare Fee Schedule (MFS) and Medicare Volume Performance Standard (MVPS) by passing along greater costs to beneficiaries through the practice of balance billing. (Levy, et al., 1992, p. NS80) Maximum Allowable Actual Charge (MAAC) eliminated this alternative by providing caps that defined the maximum level of balance billing that would be allowed. (Department of Health and Human Services, 1991, pp. 1-179) In order to gain a better understanding of how decision makers set out to achieve their goals, an overview of the mechanisms used to effect these changes is presented in Chapter II.

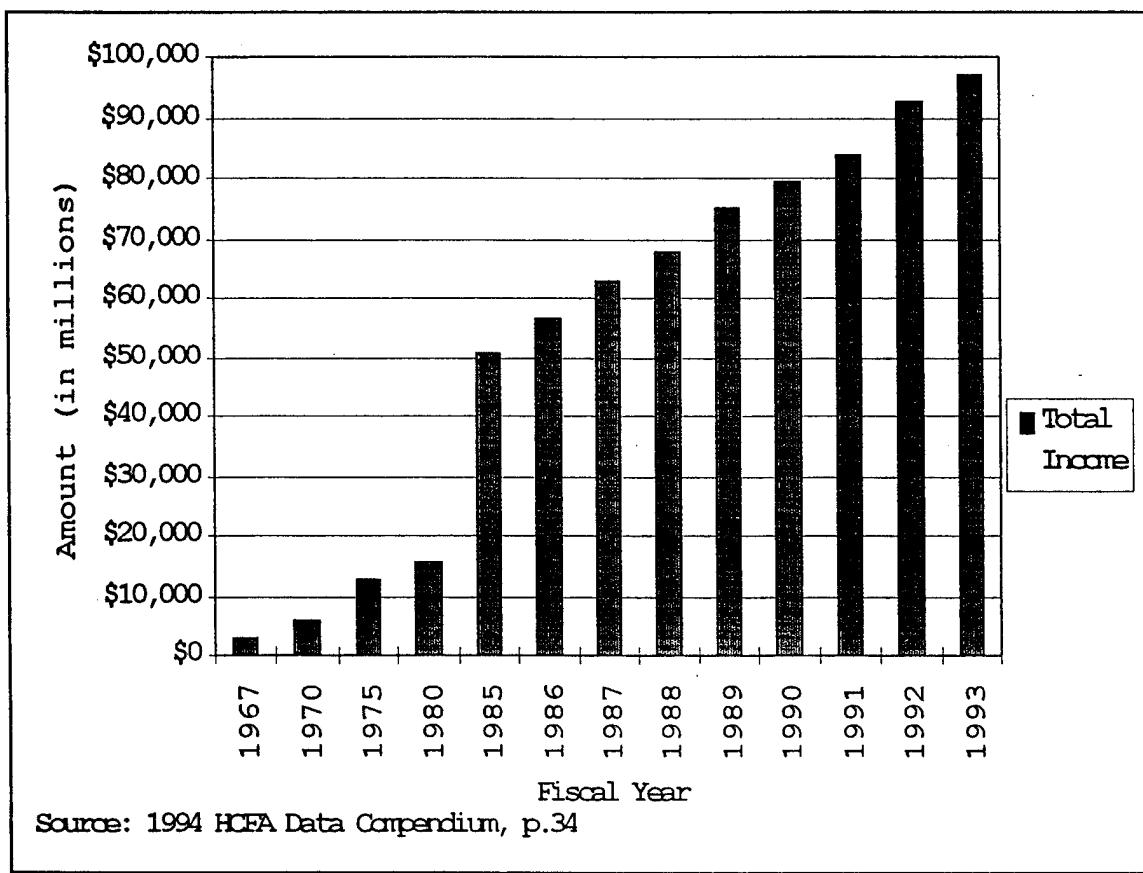


Figure 1. Hospital Insurance (HI) Trust Fund Revenue for Selected Fiscal Years.

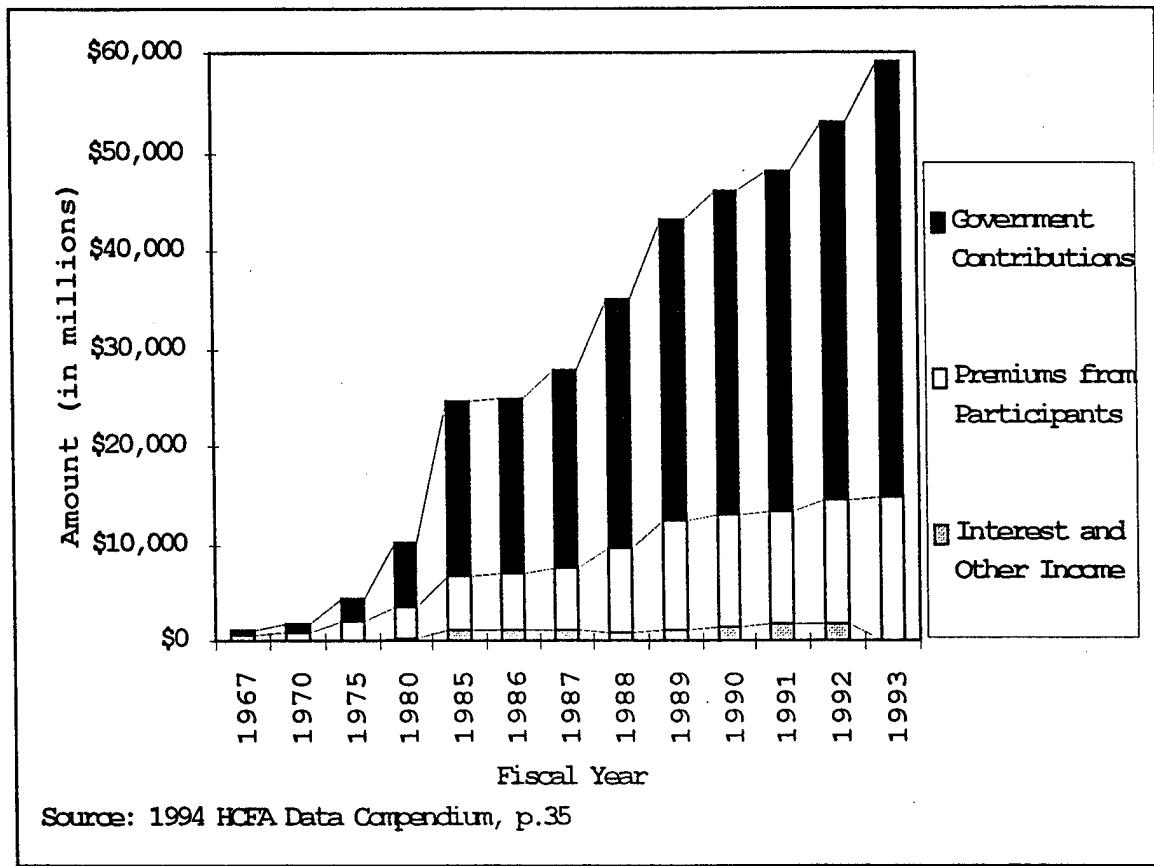


Figure 2. Supplementary Medical Insurance (SMI) Trust Fund Revenue for Selected Fiscal Years.

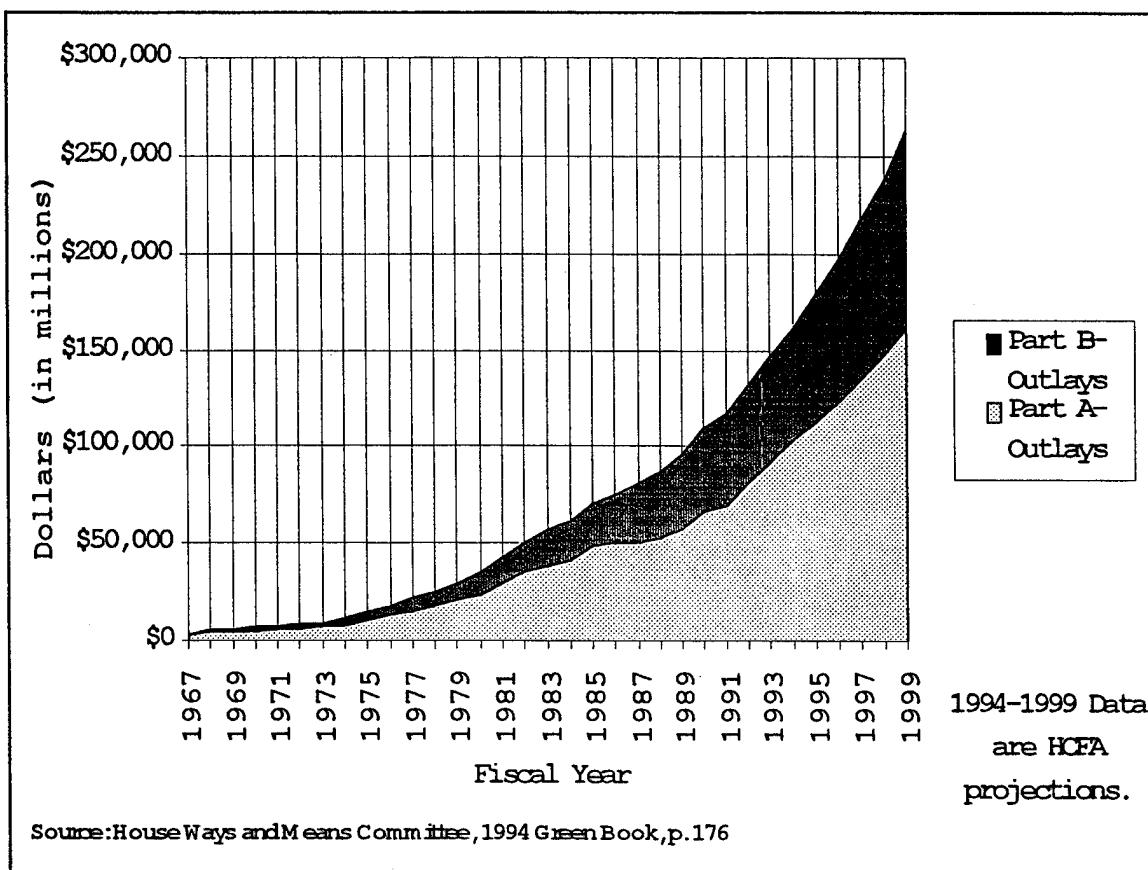


Figure 3. Medicare Outlays, Fiscal Years 1967-1999(projected).

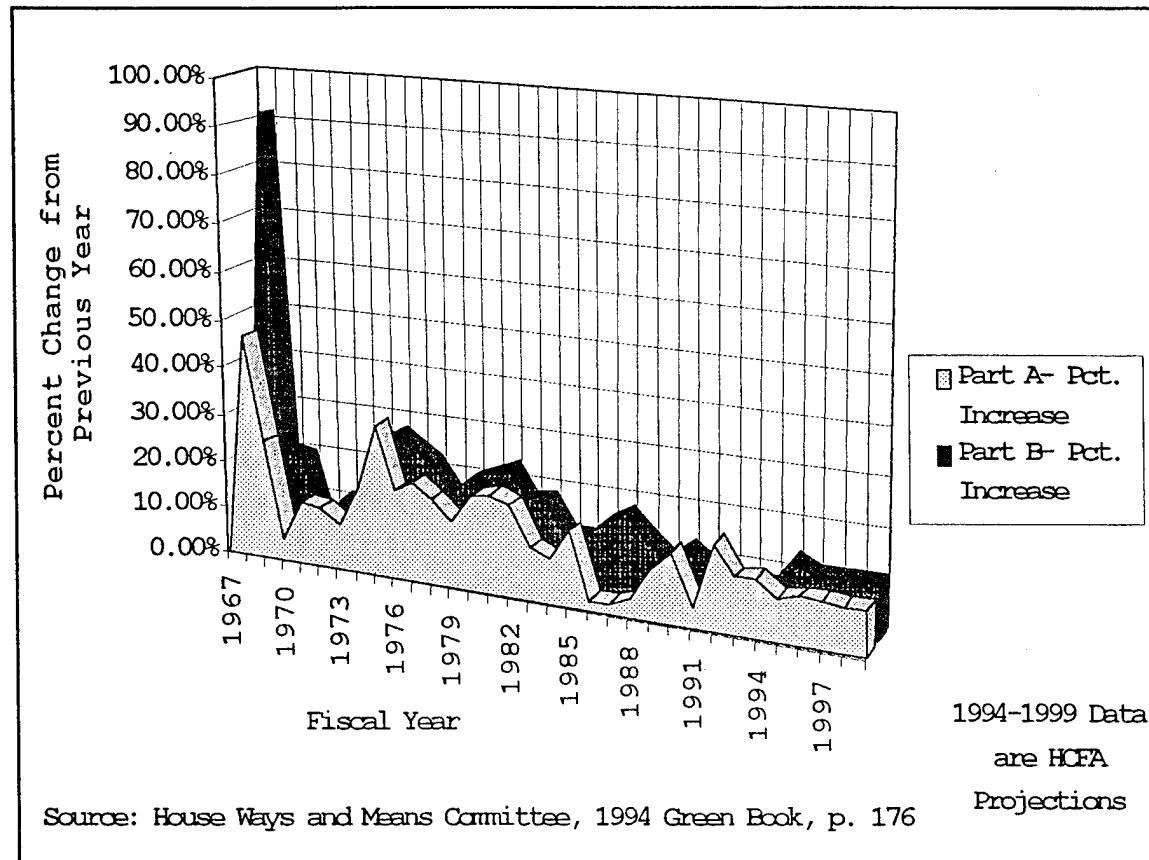


Figure 4. Medicare Cost Growth: Part A in Comparison to Part B.

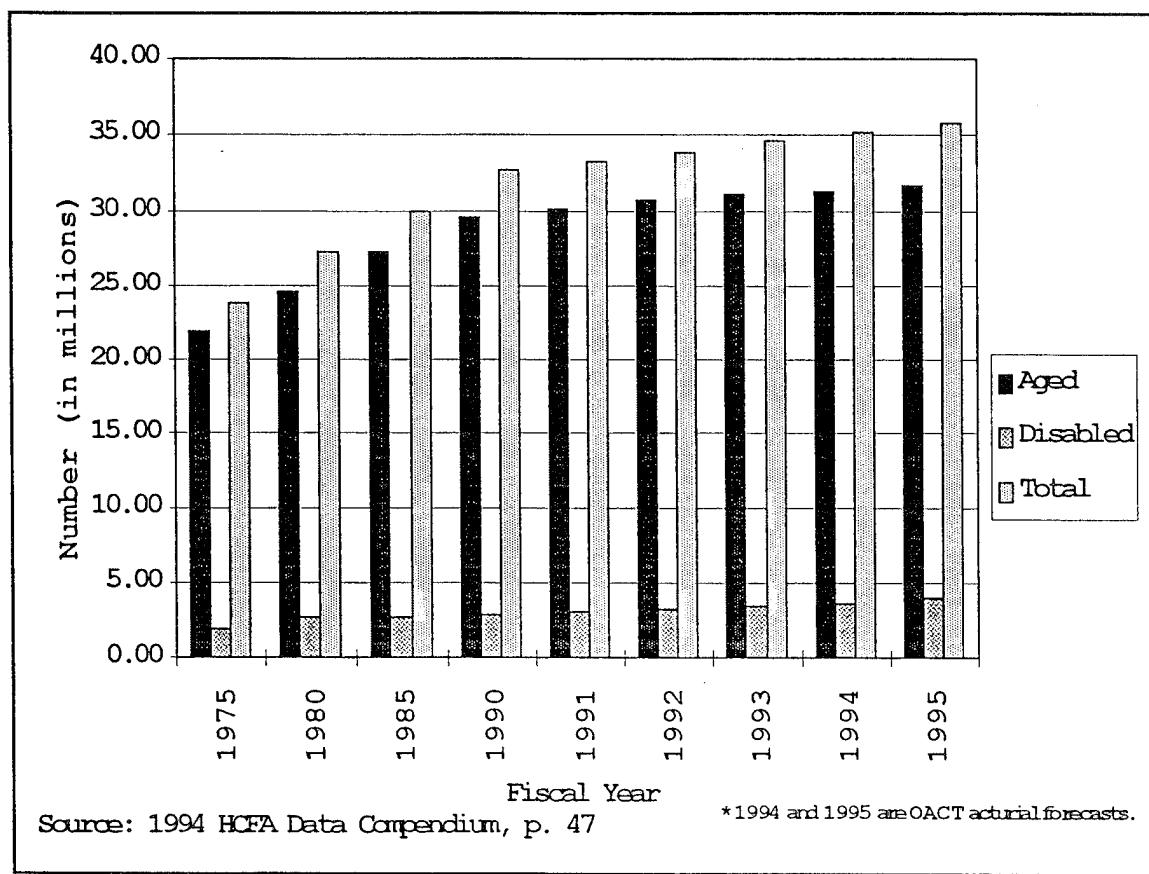


Figure 5. Medicare Enrollees: Aged, Disabled and Total.

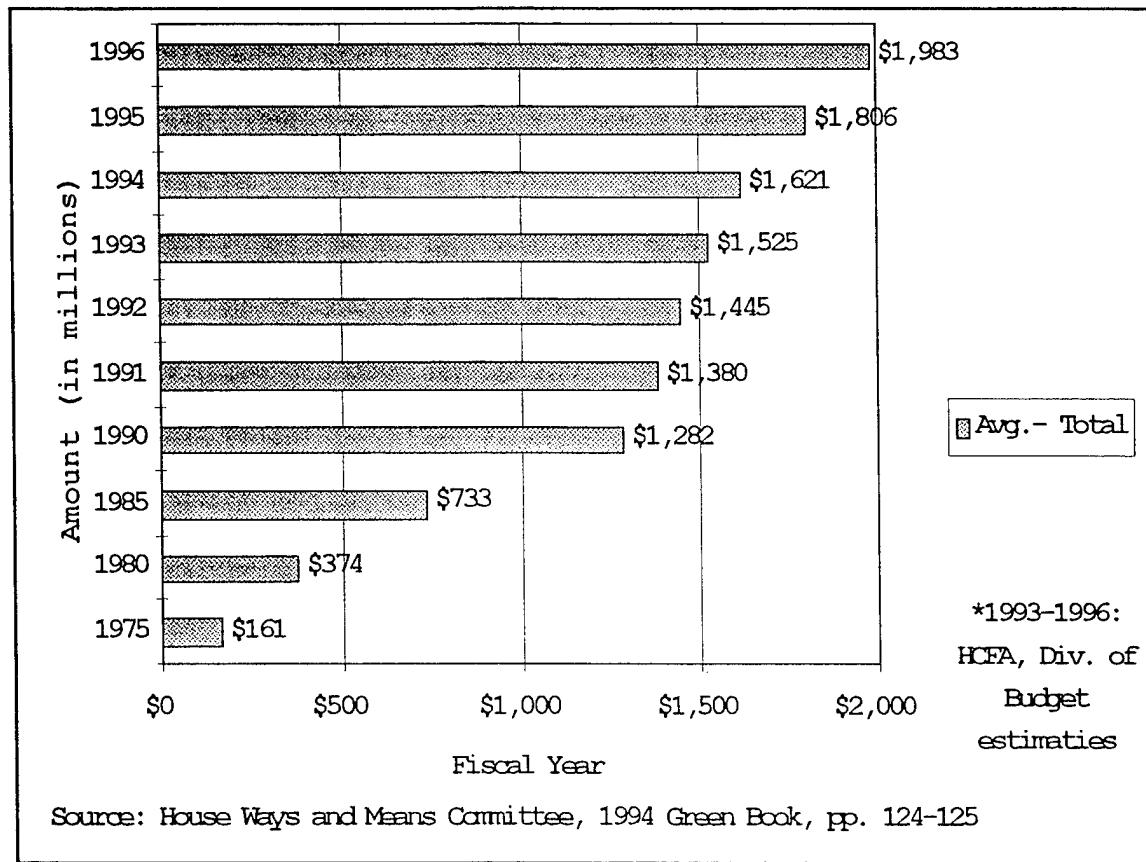


Figure 6. Supplementary Medical Insurance (SMI) Average Annual Benefit Per Enrollee.

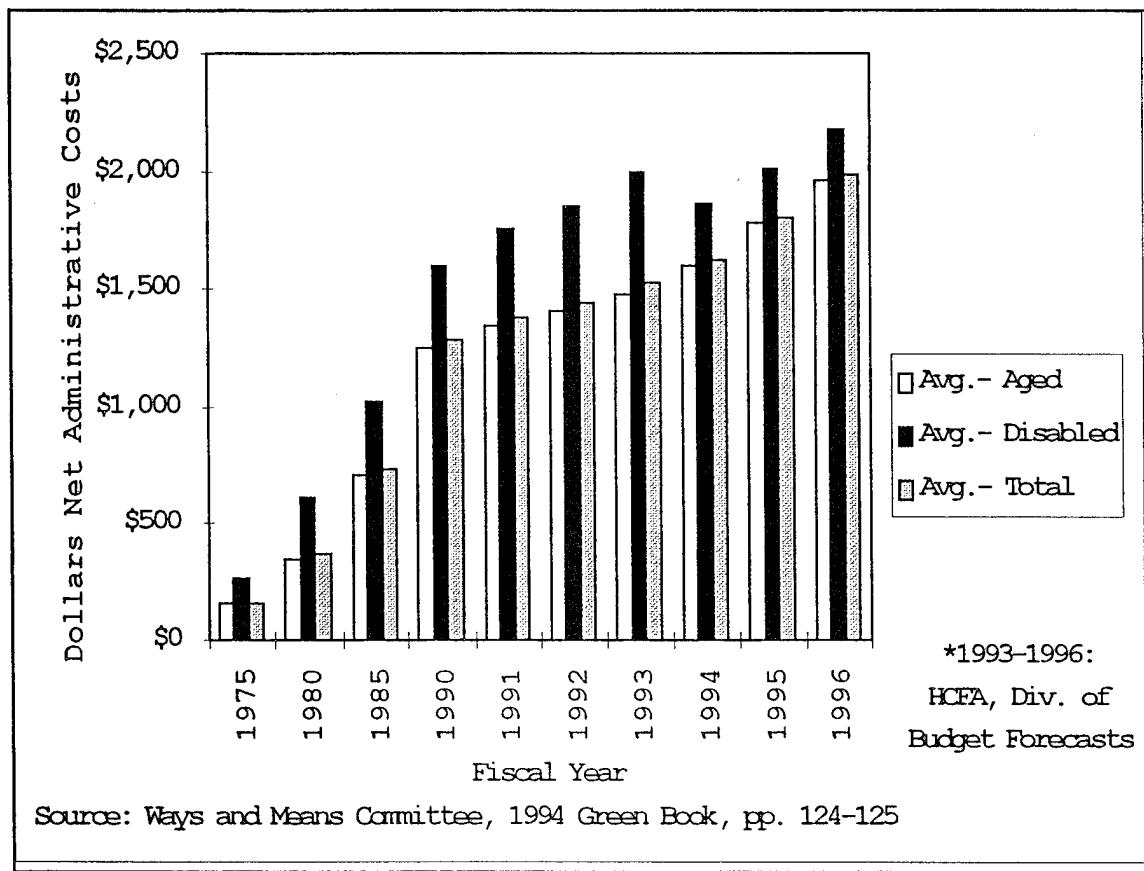


Figure 7. Average Annual Supplementary Medical Insurance (SMI) Benefit Per Person

Enrolled: Aged and Disabled.

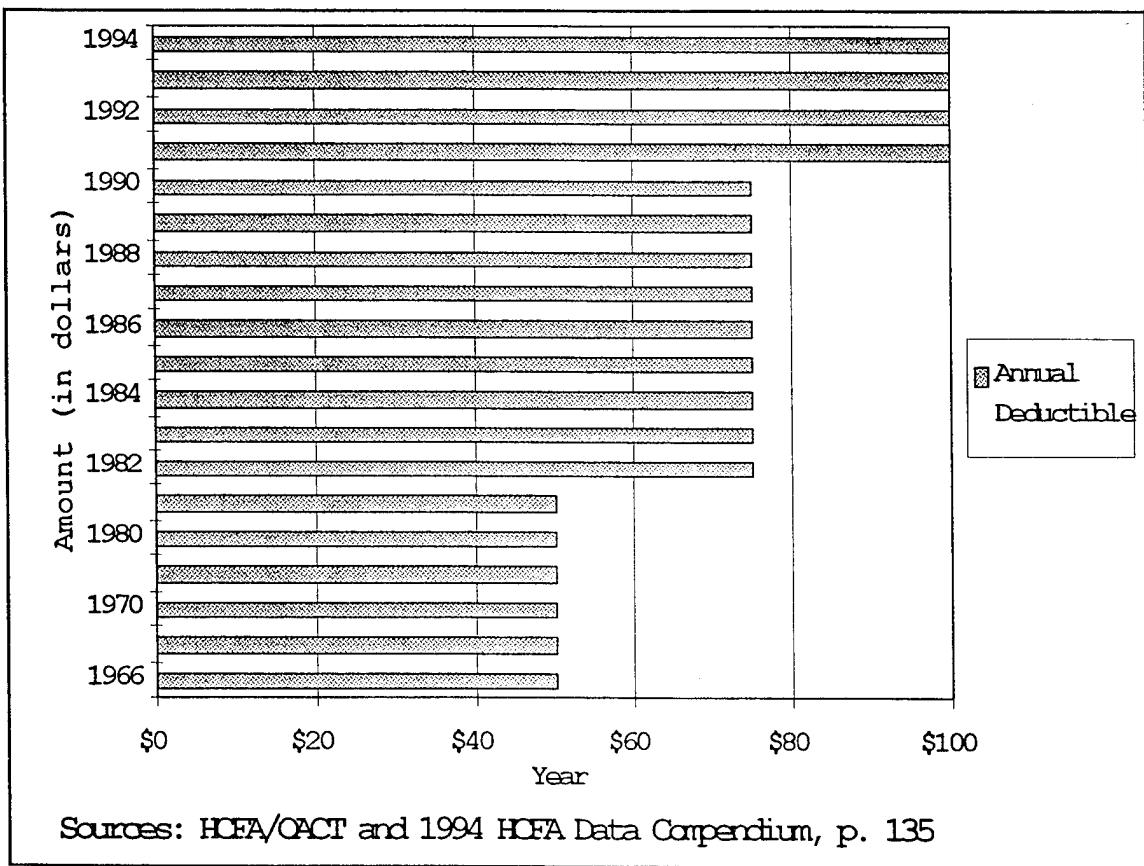


Figure 8. Supplementary Medical Insurance (SMI) Deductible for Selected Years.

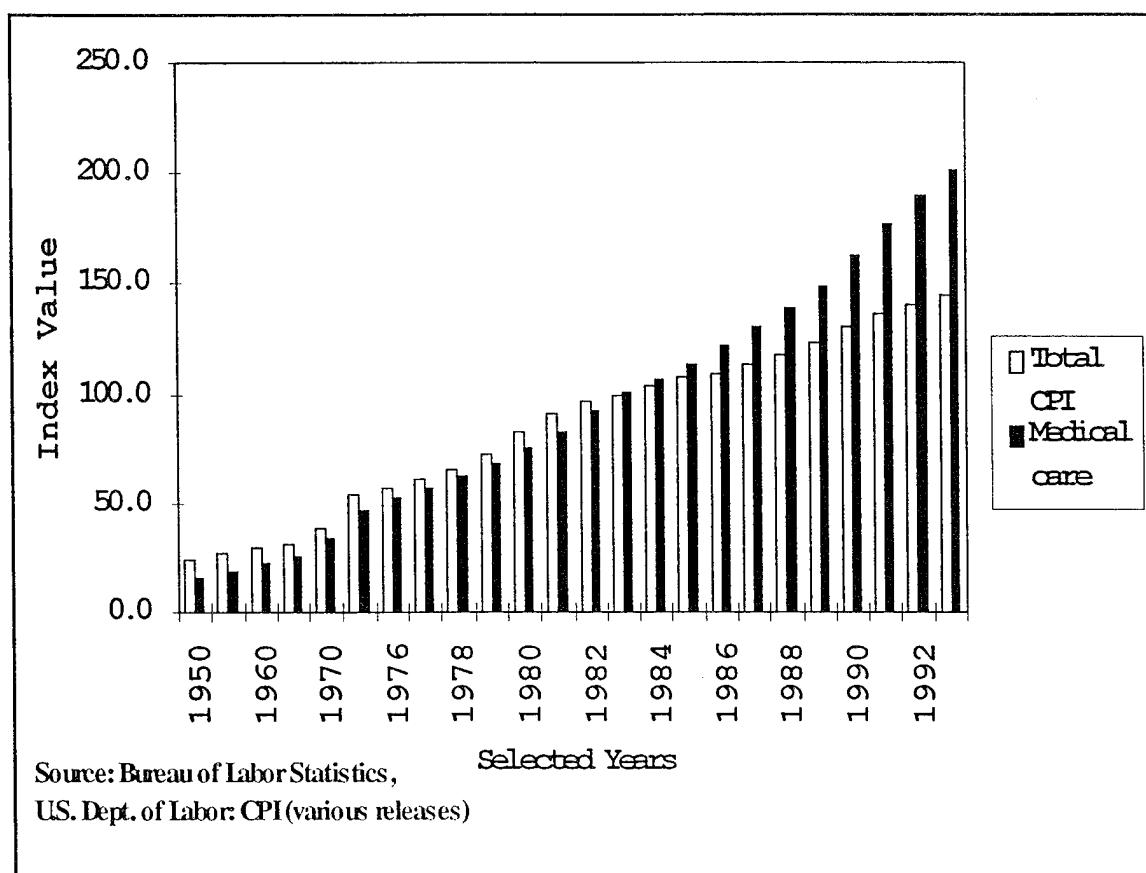


Figure 9. Total Consumer Price Index as Compared to Medical CPI.

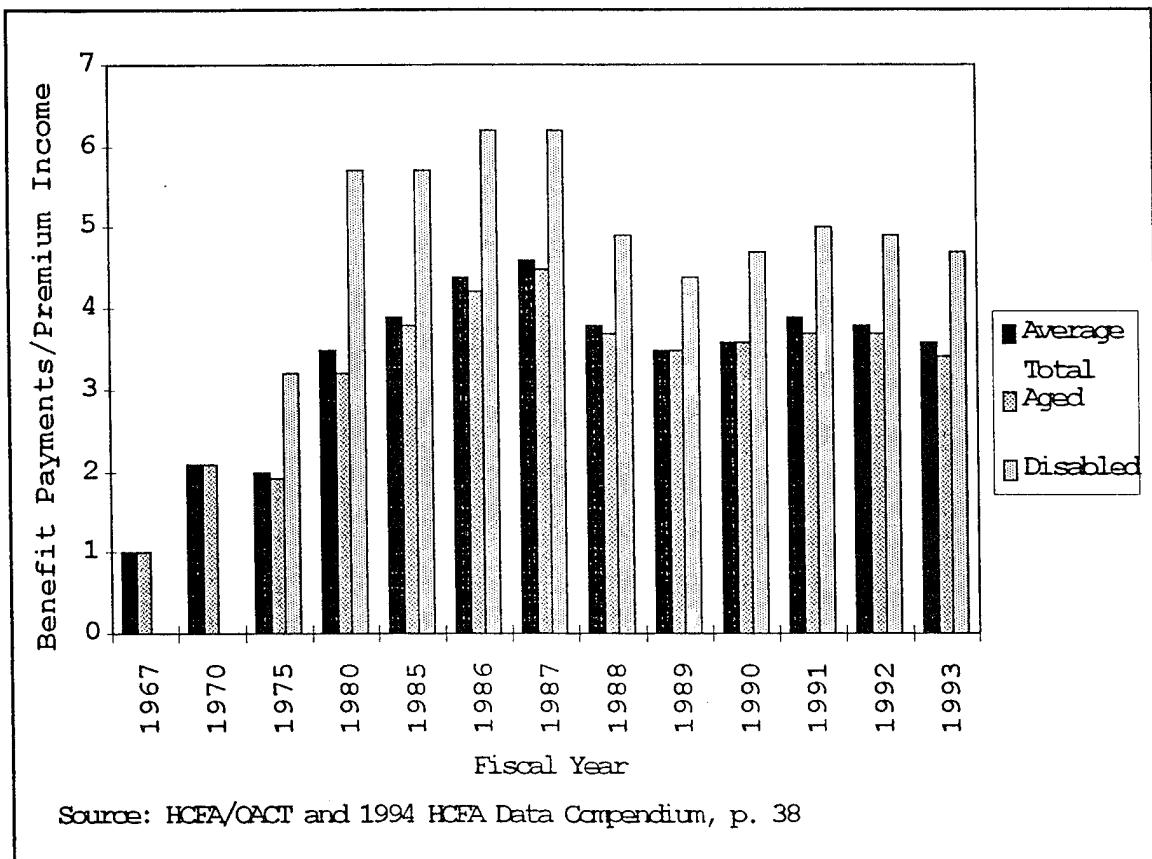


Figure 10. Supplementary Medical Insurance (SMI) Ratio of Medicare Part B Benefit Payments to Premium Income.

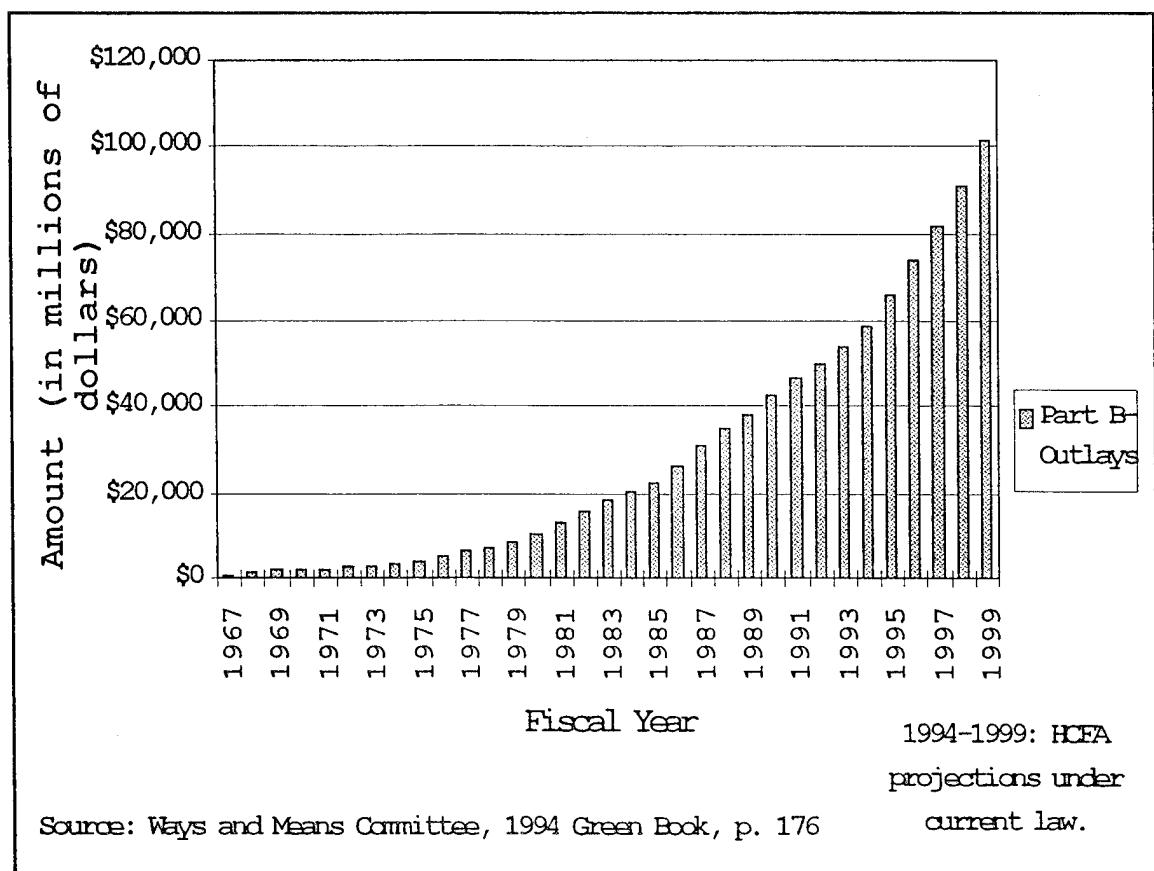


Figure 11. Supplementary Medical Insurance (SMI) Outlays by Fiscal Year.

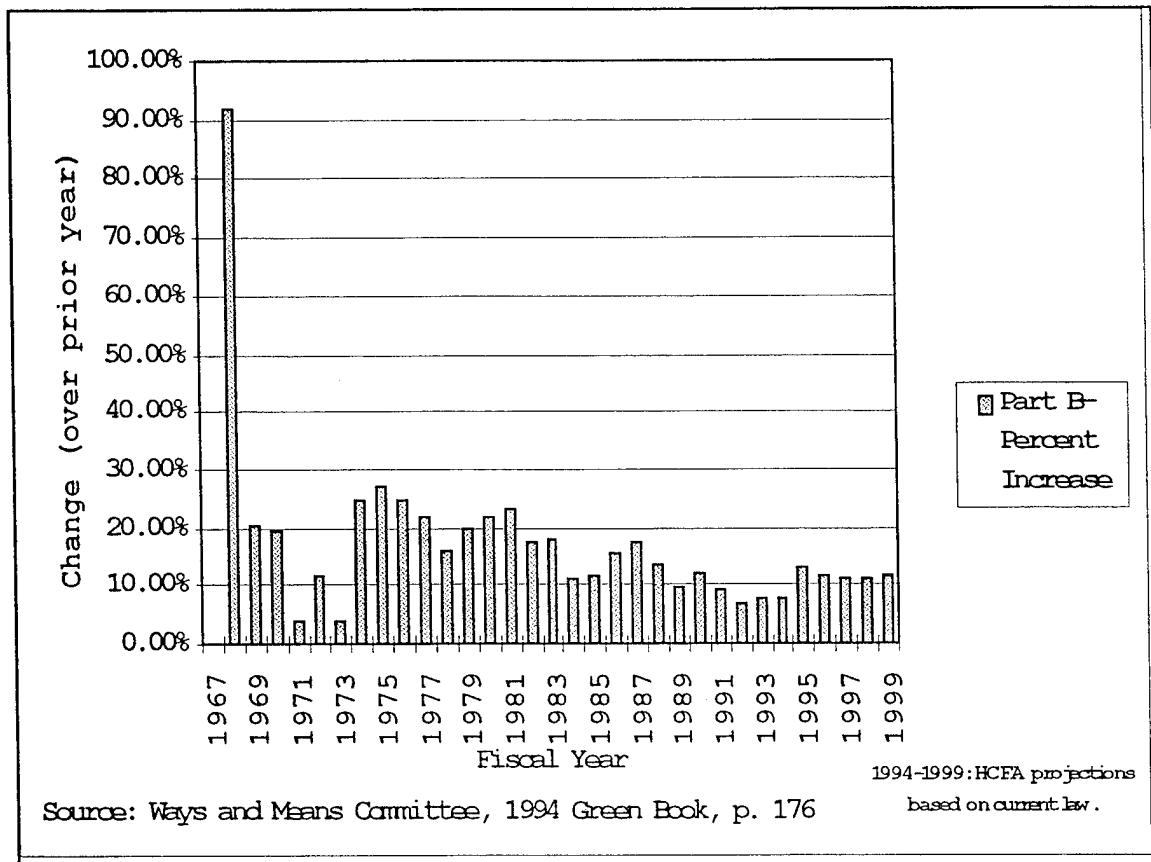


Figure 12. Supplementary Medical Insurance (SMI) Outlays: Percent Change from Prior Year.

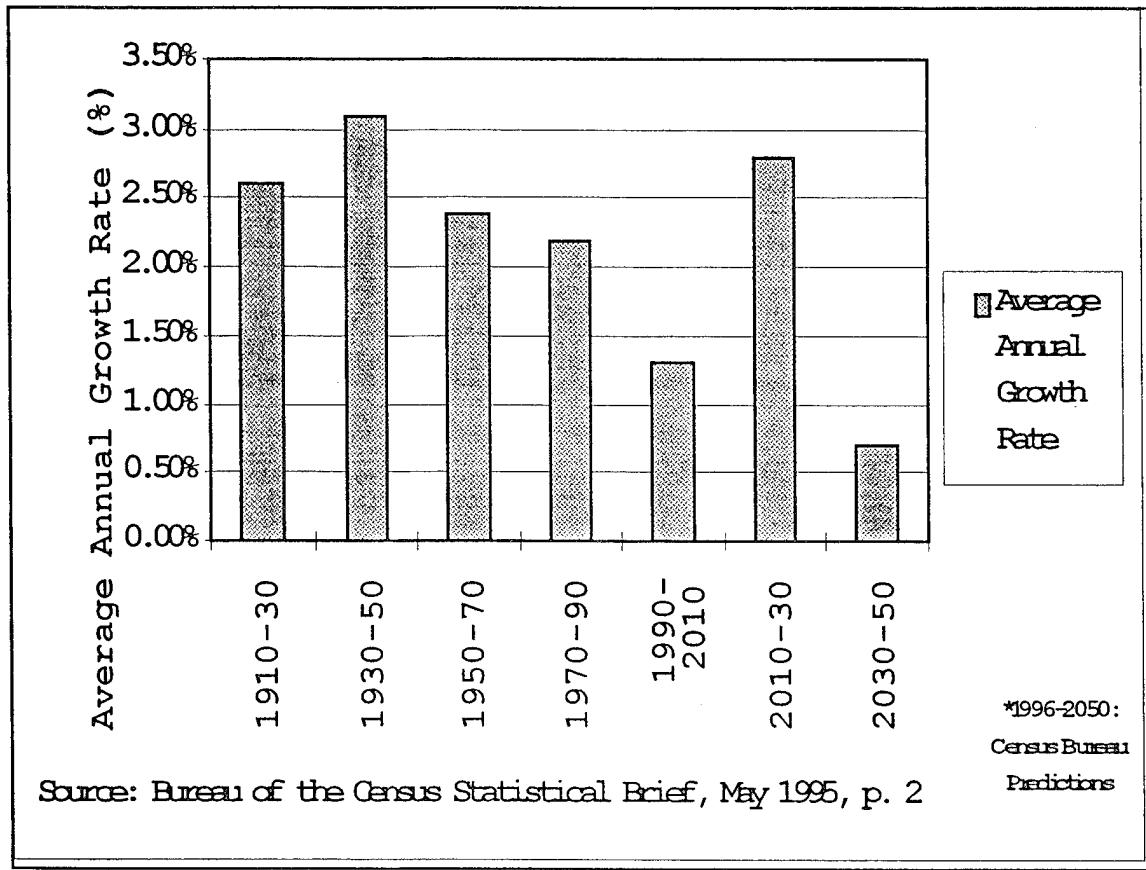


Figure 13. Average Annual Growth Rate (in percent) of the Elderly Population: 1910-30 to 2030-50.

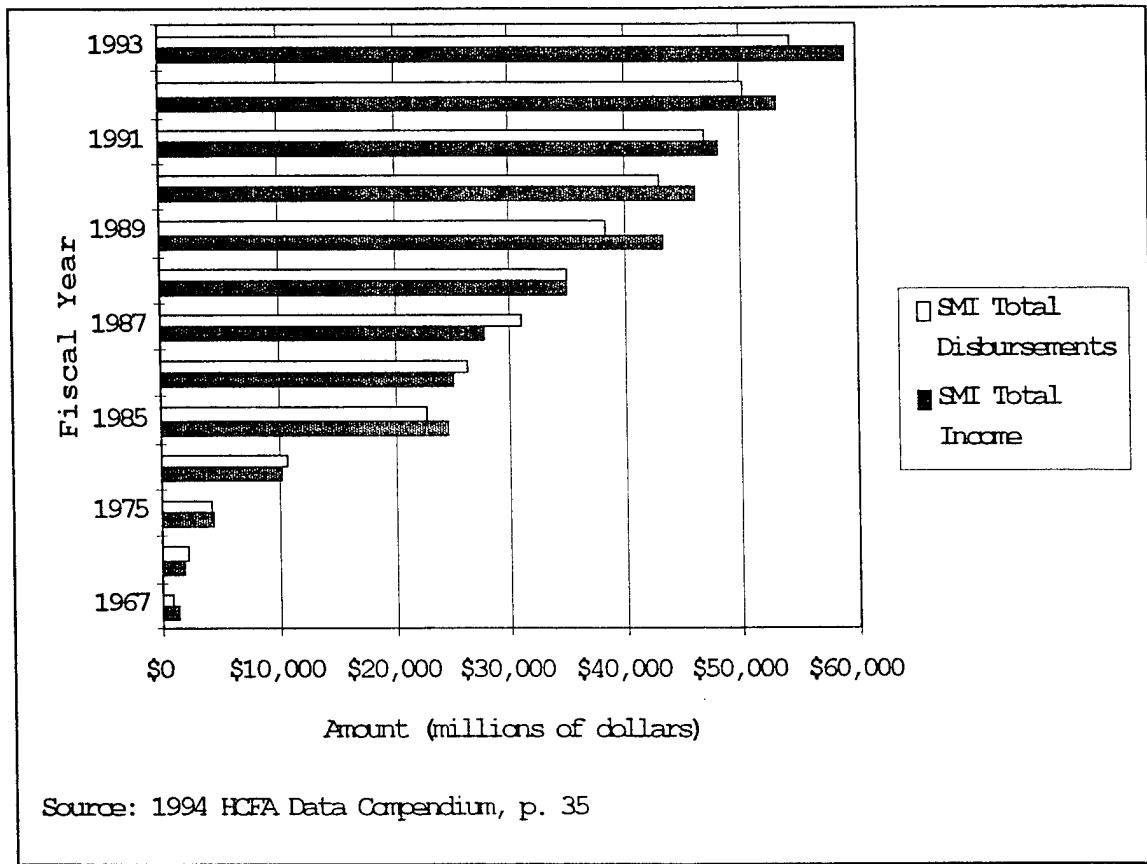


Figure 14. Supplementary Medical Insurance (SMI) Total Income Relative to Total Disbursements.

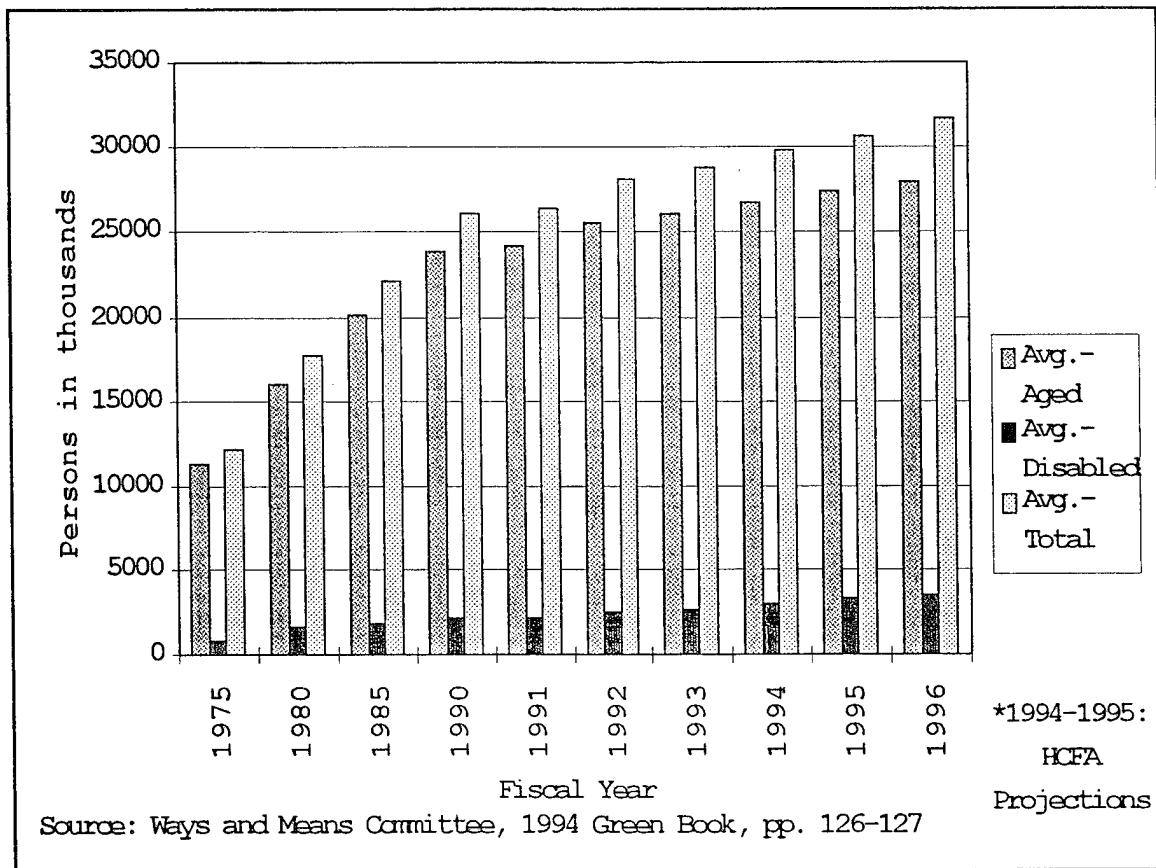


Figure 15. Supplementary Medical Insurance (SMI) Beneficiaries Receiving Reimbursed Services.

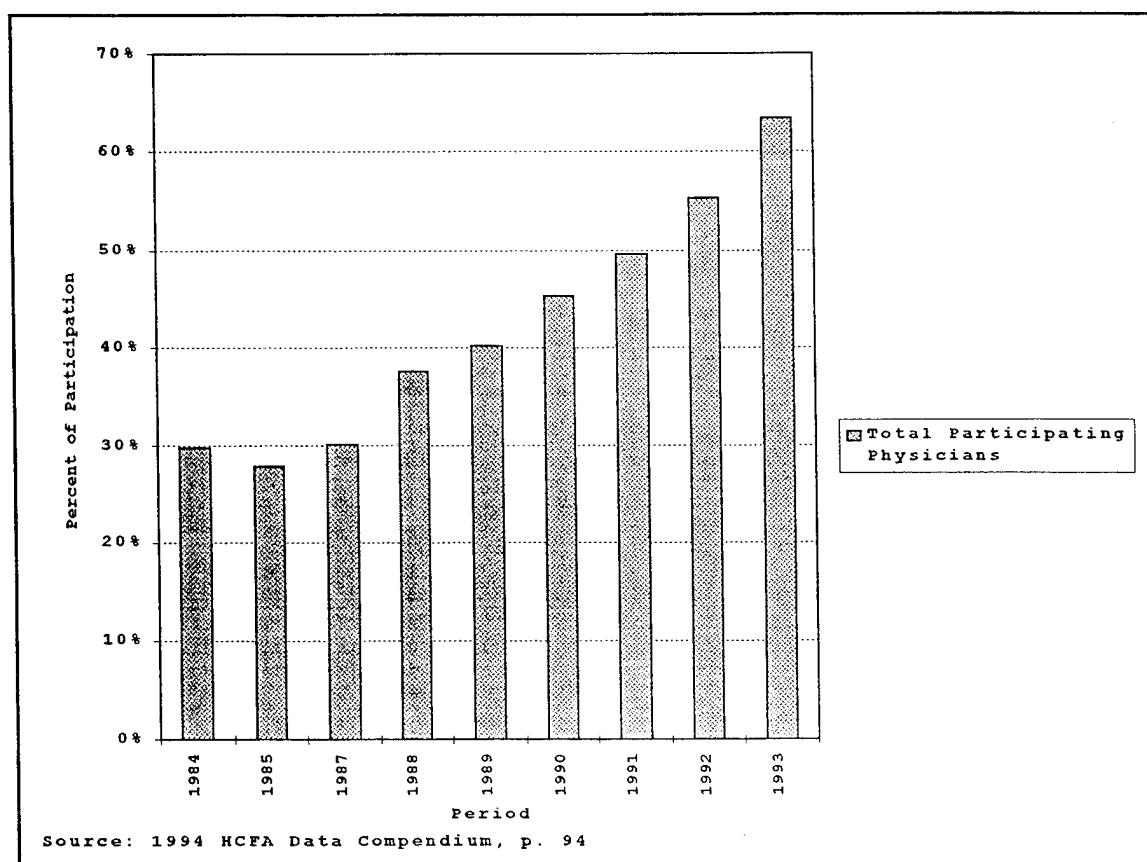


Figure 16. Physicians Formally Electing to Participate in Medicare.

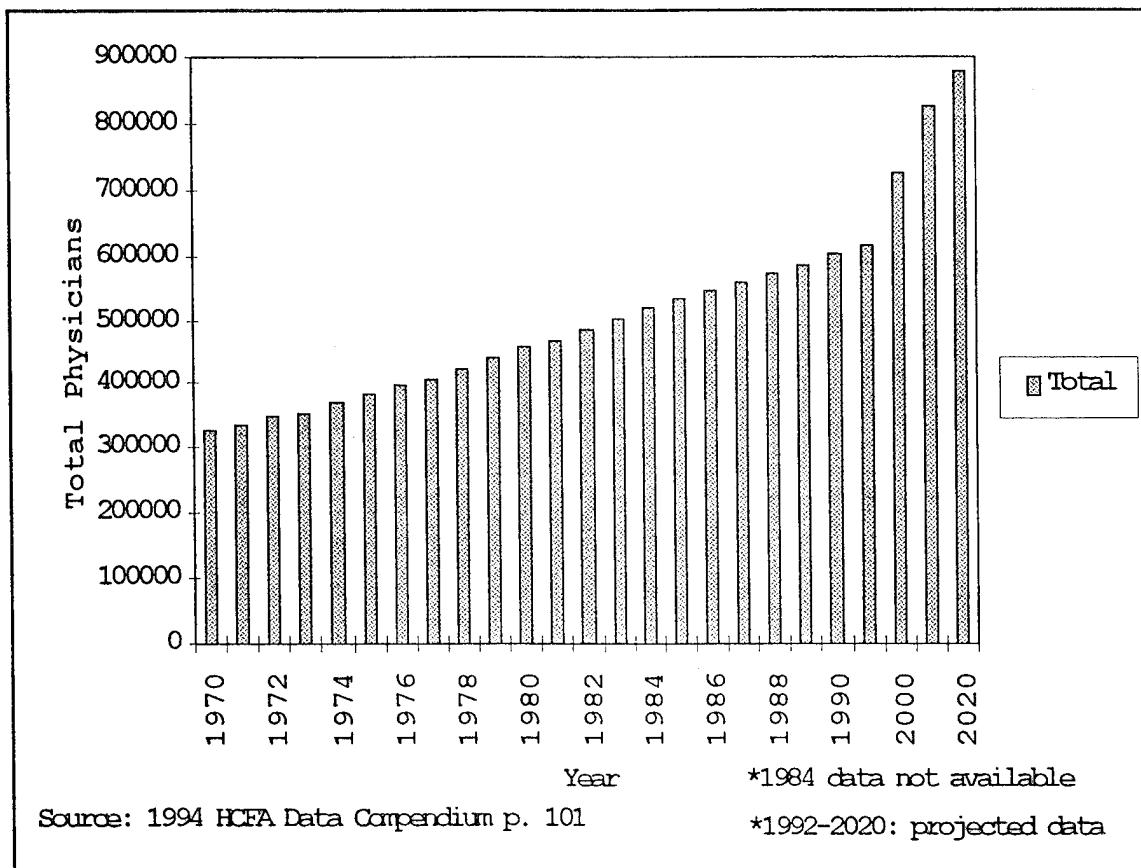


Figure 17. U.S. Active Physician Population Trends.

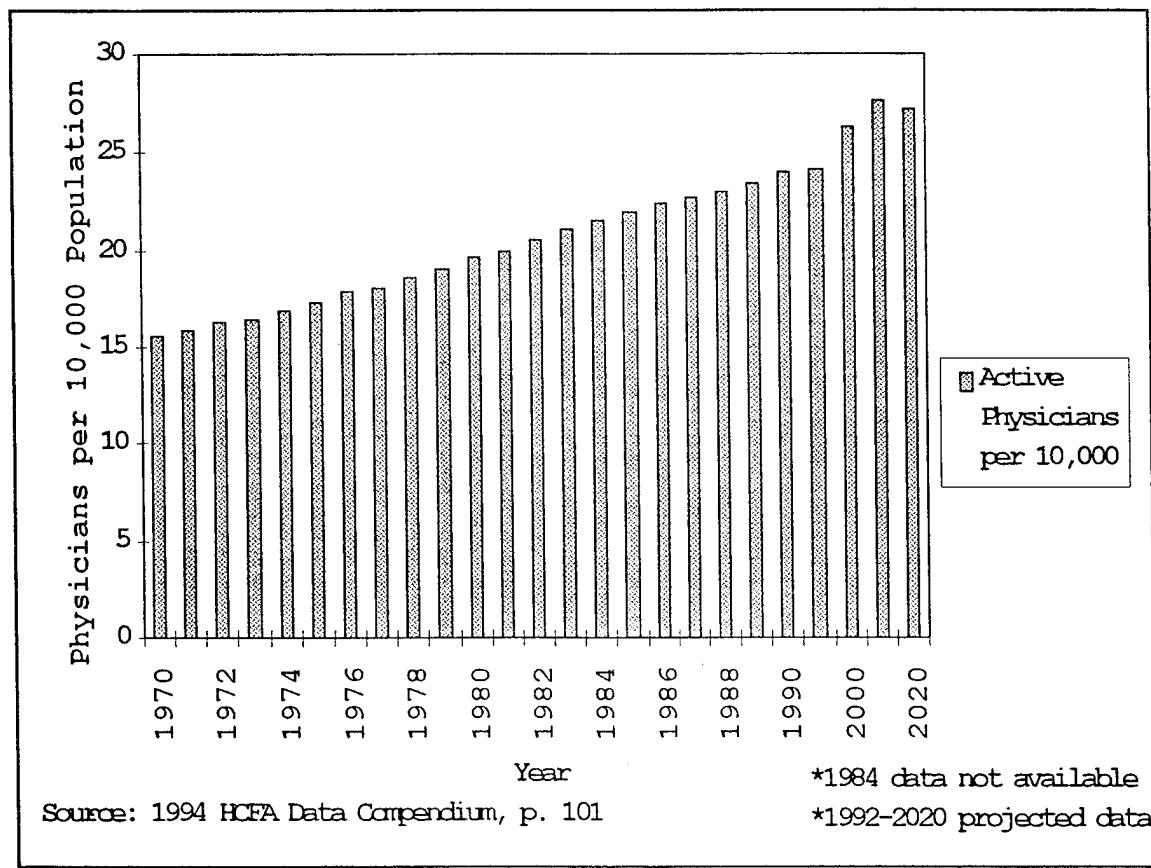


Figure 18. Active Physicians Per Ten Thousand Population.

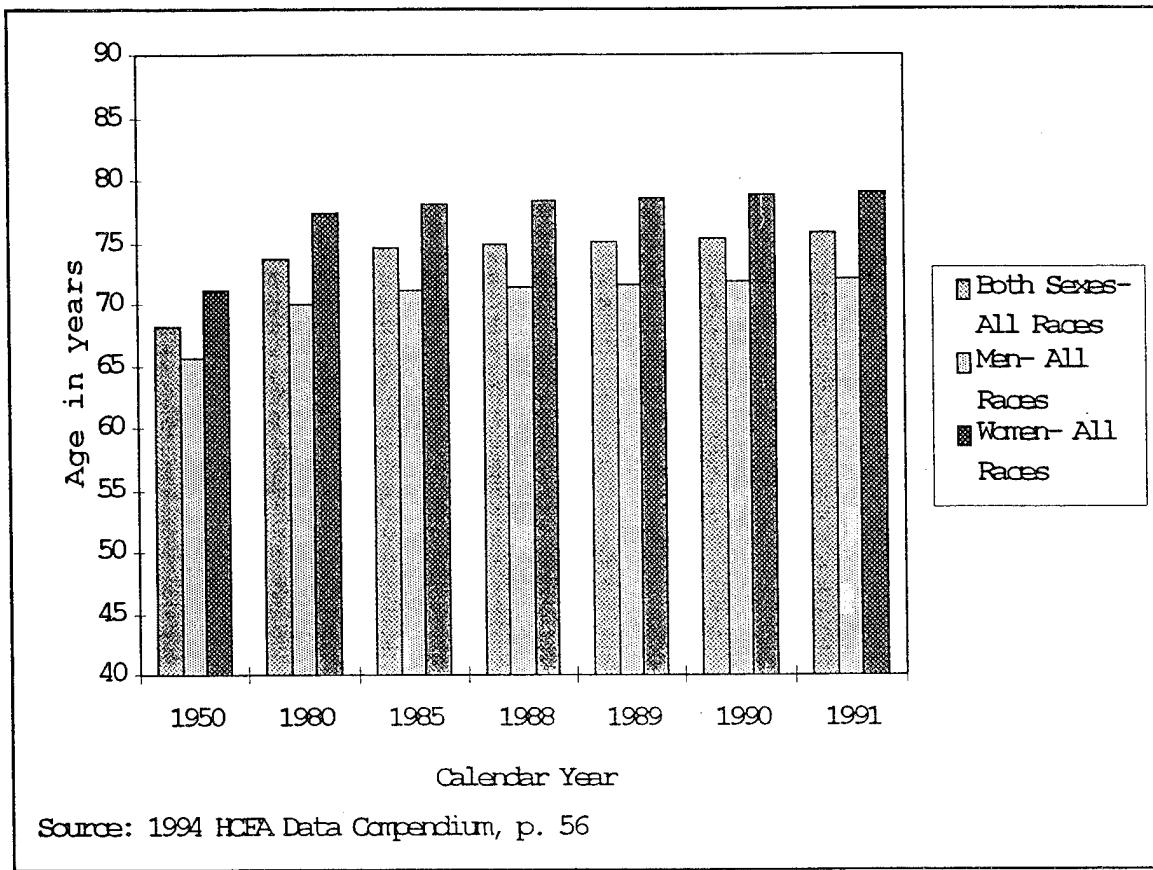


Figure 19. Life Expectancy in the United States at Birth: Male, Female and Average Total.

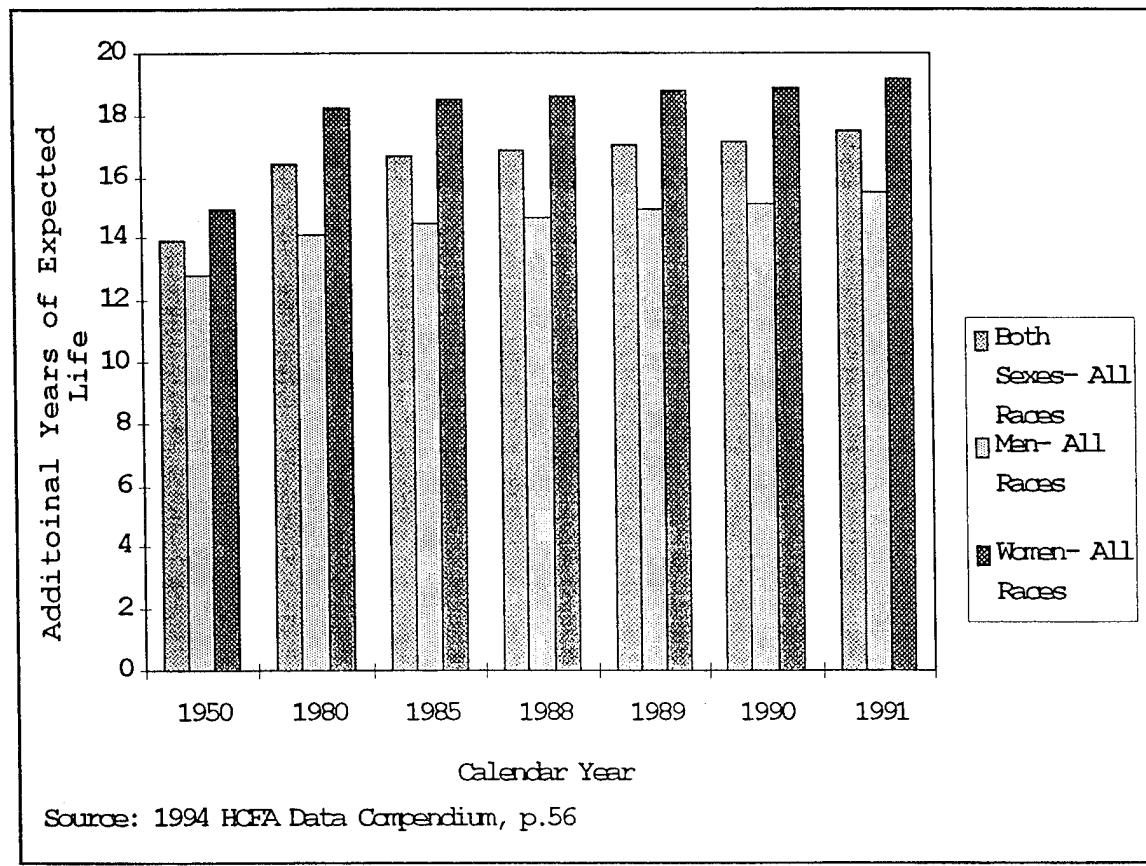


Figure 20. Additional Years of Life Expectancy at Age 65: Male, Female and Average Total.

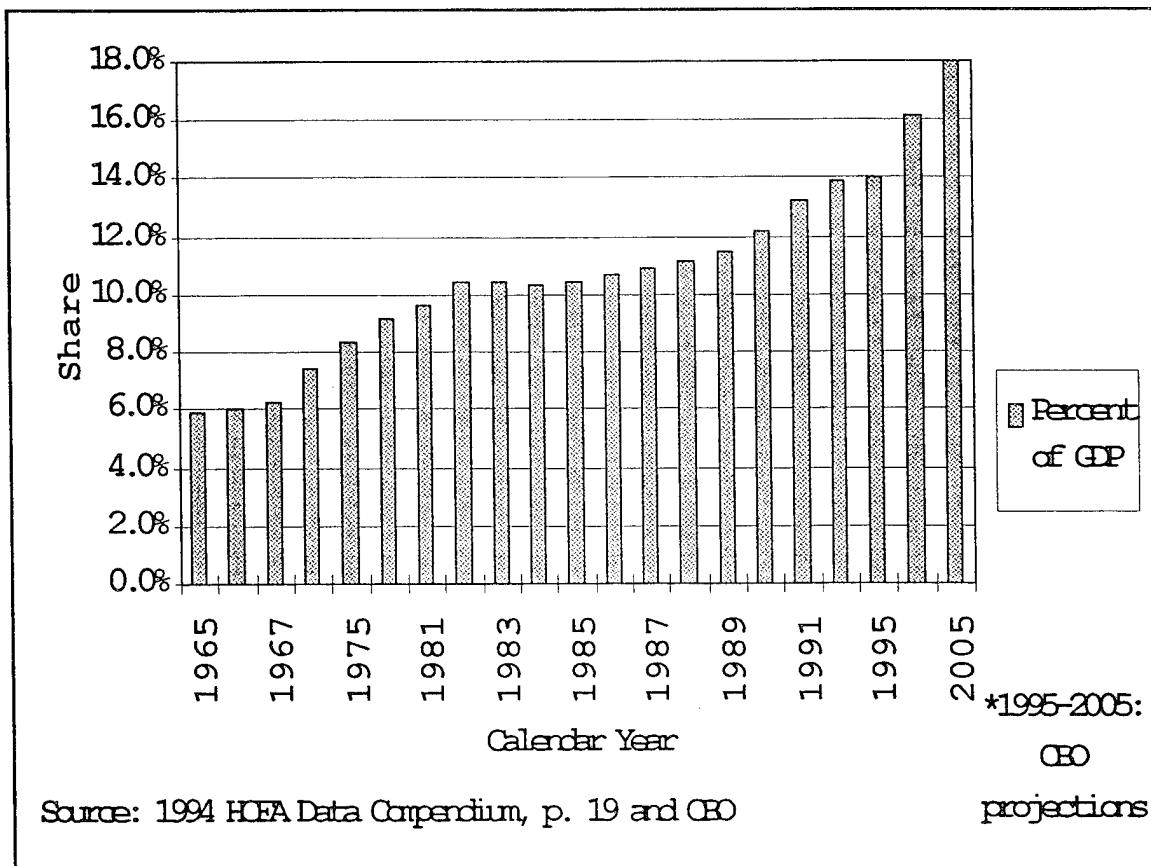


Figure 21. Health Care Demands as a Share of Gross Domestic Product.

II. PHYSICIAN PAYMENT REFORM

A. KEY EVENTS IN THE EVOLUTION OF PAYMENT REFORM

This chapter addresses the mechanics and salient policies pertaining to physician payment reform. The discussion begins with the Current, Prevailing and Reasonable (CPR) payment methodology and transitions into the requirements of the physician payment reform effort specified in the Omnibus Budget Reconciliation Acts (OBRA) of 1989 and 1990.

1. Customary, Prevailing and Reasonable (CPR) Methodology

For the first 25 years of Medicare Part B the Current, Prevailing and Reasonable (CPR) methodology was used to provide for the payment of physician services. Throughout this period the application of the Current, Prevailing and Reasonable (CPR) methodology may be viewed as undergoing three distinct phases in response to demands on the program.

The first phase occurred from 1966 through 1971. During this time, the Current, Prevailing and Reasonable (CPR) methodology achieved success at encouraging physician participation but was “widely thought to be unsatisfactory” (Congressional Budget Office, 1986, p. 26). The reasons indicated by the Congressional Budget Office (CBO) for this belief were that the Current, Prevailing and Reasonable (CPR) methodology encouraged “increases in both the price and volume of services, with resultant increases in costs for the Medicare program and Medicare enrollees (Congressional Budget Office, 1986, p. 26). These costs, resulting from the provision of an incentive structure designed to attract physician

participation, contributed toward “a higher rate of growth in Medicare’s costs for physicians’ services than can be explained by growth in Medicare enrollment and in general inflation (Congressional Budget Office, 1986, p. 28). This phase ended in 1971 when the Nixon administration sought to control growth by imposing a wage-price freeze that lasted for a period of three years.

A difference between phase one and phase two was the introduction of attempts to control the growth in program costs. When the wage-price freeze was lifted in 1975, program cost growth was no longer being determined by the customary billing practices of physicians. Although physicians were still free to charge what they desired, Medicare would only reimburse them on the basis of the allowed charge for a procedure. Specifically, the “allowable” or “reasonable charge” for a physician’s services was taken to be the lower of three rates: the actual charge, the customary charge, or the prevailing charge. The June 5, 1991 Health and Human Services (HHS) proposed rule for a fee schedule for physicians’ services defines customary charge as the median charge of the physician for the service during the July through June data collection period preceding the current calendar year and prevailing charge as the amount set high enough to cover the full customary charges of the physicians whose billings have accounted for at least 75 percent of the charges in the locality for that service (Department of Health and Human Services, 1991, p. 14).

Furthermore, with regard to growth in payment rates, the government modified the original formula to limit the rate of increase in prevailing charges to the Medicare Economic Index (MEI). (Freeland et al., 1991, pp. 61-64) Although the policies implemented during

this phase reduced the growth in costs to Medicare Part B, they placed beneficiaries at greater financial risk. This risk was a result of nonparticipating physicians being able to recover some of their lost income from beneficiaries by employing balance billing practices. (Phelps et al., 1986, p. 124) A description of this classification system and billing practice follows later in this chapter. The end of this phase, like the one before it, was marked by the imposition of price freezes. In this instance, the freezes followed the Deficit Reduction Act of 1984.

The third phase in the development of reimbursement for physician services began with the Deficit Reduction Act (DEFRA) of 1984 and lasted until the implementation of payment reform under the Omnibus Budget Reconciliation Acts (OBRA) of 1989 and 1990. Prior to the Deficit Reduction Act (DEFRA) of 1984, physicians had the flexibility of choosing whether or not to accept assignment of the Medicare allowable rate for a service on a patient-by-patient basis. The Deficit Reduction Act (DEFRA) of 1984 required physicians to choose between providing services as a participating physician and agreeing to accept assignment as payment in full for all Medicare patients or electing to be classified as a nonparticipating physician.(Congressional Budget Office, 1986, pp. 22-24) During this period incentives were structured to increase the number of physicians electing to register in a participating status. (Phelps, et al., 1986, pp. 124-125) As a result of the incentives created in this phase, beneficiaries were able to minimize their financial risk by electing to obtain their care from a participating physician.

a. Participating and Nonparticipating Physicians

(1) Participating. The Deficit Reduction Act (DEFRA) of 1984 required physicians to formally elect to be classified as “participating” or “nonparticipating physicians.” The significance of this decision was that it influenced the manner and amount in which physicians could be expected to be reimbursed for their services. A “participating” physician was an individual who agreed to accept “assignment” on all claims for Medicare participants covered by the program. Acceptance of assignment was the physician’s consent to accept the Medicare allowable charge as payment in full for a service. Consequently, a participating physician did not use “balance billing,” the practice of billing patients for the marginal difference between the Medicare payment rate and the physician’s actual charge for a service. Instead, the participating physician was able to receive 80 percent of the allowable charge for the service directly from Medicare. They would then be responsible for billing the beneficiary for the remaining 20 percent or coinsurance portion of the allowable charge. In 1989, about 45 percent of all licensed physicians signed “participating” agreements with Medicare and more than 60 percent of Medicare payments were made to “participating” physicians. (Congressional Budget Office, 1990)

(2) Nonparticipating. “Nonparticipating” physicians could, on a claim-by-claim basis, elect to reject assignment of the Medicare allowable charge. Relative to Medicare reimbursement levels, rejection of assignment brought financial consequences and a degree of risk for the physicians. A nonparticipating physician who did not accept assignment would be compensated at a rate of 95 percent of that received by participating

physicians in the locality. The coinsurance portion paid by the beneficiary, traditionally 20 percent of the allowable charge, would also be based on this reduced rate. However, unlike the "participating" physician, a "nonparticipating" physician was able to employ the practice of "balance billing." The amount contained in the balance billing portion of the transaction was determined by subtracting the Medicare allowable rate from the nonparticipating physician's fee for the service. The balance billing portion of the fee could only be recovered from the beneficiary. For example, if a nonparticipating physician billed \$110 for a service and the Medicare allowable charge for the service was \$100 the physician would be paid as follows:

- Medicare's share: $\$100 \times 95\% \times 80\% = \76
- Coinsurance share: $\$100 \times 95\% \times 20\% = \19
- Balance billing total: $\$110 - \$95 = \$15$
- Total received by physician = $\$76 + \$19 + \$15 = \110 .

In addition to the lower prevailing fees for nonparticipating physicians and the increased administrative effort and risk of default associated with balancing billing practices, the Deficit Reduction Act (DEFRA) of 1984 provided additional incentives to elect to become a participating (PAR) physician. These incentives included "directories of participating physicians, dissemination of names of participating physicians via toll-free telephone numbers, and provision for electronic receipt of claims by carriers"(Health Care Financing Administration, 1992, p. 161).

Another incentive to encourage participation was also provided by the Deficit Reduction Act (DEFRA) of 1984. Under its provisions and beginning in 1984, the allowed costs for physician services were to be frozen until October 1985. Although the freeze was intended to last fourteen months, its final duration was dependent upon the participation status of physicians. For participating physicians the freeze ended on May 1, 1986, while nonparticipating physicians were extended until January 1, 1987. (Congressional Budget Office, 1986, p. xvi) During the period between May 1, 1986 and January 1, 1987 “participating physicians were allowed to increase charges to Medicare patients . . . to establish a higher fee level for subsequent periods”(Phelps et al, 1986, p. 142). However, nonparticipating physicians were not given the same opportunity. A result of this policy was that more physicians elected to accept assignment with the hope of achieving higher future fee levels. Participation increased from approximately 59 percent of the physician population in 1984 to 68.5 percent in 1985 (Phelps, et al, 1986, p. 142).

B. CHANGE IN PHYSICIAN REIMBURSEMENT: OBRA 89 AND OBRA 90

In 1988, Congress provided the Physician Payment Reform Commission (PPRC) with a mandate that included instructions to consider “policies to moderate the rate of increase in (physician payment) expenditures and the use of services (Lee, 1990, p. 277). The Physician Payment Reform Commission’s (PPRC) recommendations became the basis for the payment reform effort specified by Congress in the Omnibus Budget Reconciliation Acts (OBRAs) of 1989 and 1990 (Lee, 1990, p. 270). The 1989 bill had three objectives: “1) to create equitable prices for Medicare physician services; 2) to reduce the explosive growth in

Medicare Part B expenditures; and 3) to protect beneficiaries from increased liability" (Levy, et al., 1992, p. NS80). The Medicare Fee Schedule (MFS) was implemented to address the perception of inequities in the Part B reimbursement method (Levy, et al., 1992, pp. NS80-NS81). Part B cost growth was addressed in the methodology provided under the Medicare Volume Performance Standard (MVPS) (Levy, et al., 1992, pp. NS80-NS81). In response to increased recipient cost liability, the practice of "balance billing" was addressed in the revision of the Maximum Allowable Actual Charge (MAAC) mechanism (Levy et al., 1992). All three mechanisms are to some degree interdependent and are discussed below in the section headed "Physician Payment Reform." A diagram of these mechanisms and their key components is provided in Figure 22.

1. Requirements of OBRA 89 and OBRA 90

The Omnibus Budget Reconciliation Act (OBRA) of 1989, amended by the Omnibus Budget Reconciliation Act (OBRA) of 1990, are the legislative vehicles that directed the implementation of the resource based physician fee schedule. This section addresses both the qualitative and quantitative aspects of these requirements.

2. Reform Mechanisms

a. *The Medicare Volume Performance Standards (MVPS)*

In order to place a control on the rate of growth for payment rates Congress required the establishment of a volume performance standard rate for updating physician payment rates. (Rice and Bernstein, 1990, p. 295). Prior to its implementation and after 1975 allowable charges were permitted to increase at a rate specified by the Medicare Economic

Index (MEI). With the implementation of the volume performance standard methodology, an allowable growth rate or “update factor” was introduced. This factor is determined by one of two methods: congressional action or by use of the “default formula” methodology.

If Congress chooses to, they may establish an “update factor” in law. Under this option, the Secretary of Health and Human Services (HHS) and the Physician Payment Review Commission (PPRC) would provide a recommended value for the “update factor” to the Congress. The recommended value must allow for factors such as “inflation, changes in the volume and intensity of services, access to services, and past experience with Medicare spending on physician services. (Department of Health and Human Services, 1991, p. 75)

Upon receipt of the recommendation from the Secretary of Health and Human Services “Congress may choose to enact the Secretary’s recommendation, enact some other update amount, or not act at all” (Department of Health and Human Services, 1991, p. 75). If Congress elects not to act, a “default target” is provided under the law (Congressional Budget Office, 1990, p. 12). The default target method uses the relationship provided in Figure 23 to determine the value for the update factor. This relationship relies on both projected and historic values. Specifically, the dependent variable, the update factor, is determined by the relationship between three independent variables: a) the projected Medicare Economic Index (MEI) for the following year, b) the “default target” from the previous year, and c) the actual growth in Medicare expenditures from the previous year.

The projected Medicare Economic Index (MEI) is an estimate of the growth expected to take place in factors such as “a) physician earnings, b) nonphysician earnings, c)

medical office expenses, d) medical supplies and resource materials, e) professional liability costs, and f) medical equipment costs" (Graboyes, 1994, p. 69). The "default target," taken from the previous year, comprises four factors: 1) the average percentage change in payment rates projected for the year; 2) the percentage change in expenditures for physicians' services expected to result from changes in law or regulations; 3) the percentage change in the number of Medicare enrollees who will receive physicians' services in the fee-for-service sector; and the average annual percentage change in the volume of physicians' services per enrollee over the previous five years, minus a "performance standard factor" (PSF). The performance standard factor (PSF) is set by law at 0.5 percent for 1990, 1 percent for 1991, 1.5 percent for 1992, and 2 percent for 1993 and subsequent years (Congressional Budget Office, 1990, p. 12). Actual growth in Medicare expenditures is measured retrospectively, using data for the previous year.

The default "update factor," under the default target method, is then calculated as depicted in Figure 23. Specifically, the default update rate would be equal to the projected Medicare Economic Index (MEI) plus the difference between the "default target" and the "actual growth rate" from the prior calendar year. An example of this calculation is provided in Figure 24. It should be noted that during the Medicare Fee Schedule (MFS) transition period, Congress imposed limitations on the size of downward adjustments that may be implemented as a result of this process. The magnitude of downward adjustments was capped at 2 percentage points for 1992 and 1993, 2.5 percentage points for 1994 and 1995 and three percentage points for subsequent years (Congressional Budget Office, 1990, p. 13).

b. The Medicare Fee Schedule (MFS)

The second requirement of the Omnibus Budget Reconciliation Acts (OBRA) of 1989 and 1990 was the replacement of the Current, Prevailing and Reasonable (CPR) payment mechanism with a new fee schedule for physicians' services. As indicated in Figure 1, the new Medicare or Physician Fee Schedule (MFS) was based primarily on three elements: 1) a relative value scale that ranks one service in relation to all others; 2) a geographic factor that adjusted for the cost differences in providing services in different geographic locations; and 3) a conversion factor that translated relative values and geographic adjustments into a dollar value for a service.

The payment amount for a service covered by the Medicare Fee Schedule (MFS) may be calculated using the relationship provided in Figure 25. The variables presented in this form of the Medicare Fee Schedule (MFS) equation represent a service, S, being provided in a locality, A. For example, the relationship given in Figure 4 may be used to calculate the Medicare Fee Schedule (MFS) allowable charge for treating an infection (S) by applying a measure of the Relative Value Units (RVUs) associated with the procedure, adjustments for geographic costs associated with the location of the physician and a conversion factor that translates the Relative Value Units (RVUs) and geographic factors into a dollar amount. In the case of providing treatment for the infection, the relevant quantities would be the relative value of the physician's effort relative to the range of all other available procedures (RVUwS), the relative value of practice expenses incurred in support of treating the infection (RVUpes), the relative value of malpractice insurance expense allocable to

treatment of the infection (RVUmS), the geographic adjustment factors that would adjust the Relative Value Units (RVUs) for geographic location (GPCIwA, GPCIpeA and GPCImA) and the Conversion Factor (CF) that had been determined by the Health Care Financing Administration (HCFA).

(1) Relative Value Scale (RVS). One of the three components of the Medicare Fee Schedule is the relative value scale (RVS). The relative value scale (RVS) established a hierarchy that compares and ranks different types of physician services across specialties based on a measure of physicians' work, a measure of the physicians' practice costs used to support the service, and a measure of malpractice insurance costs. The physicians' work scale was developed by a three-phased Health and Human Services (HHS)-sponsored study executed by a Harvard University research team. (Health and Human Services, 1991) Practice expense and malpractice Relative Value Units (RVUs) were developed, as described below, using a different methodology.

In determining the appropriate Relative Value Units (RVUs) assigned to physicians' work, the Harvard study focused on the resources required by a physician to perform a service. The first phase of the study used a national survey in which random samples of 185 physicians in each of 18 specialties were selected. As part of the survey short descriptions or vignettes of physician services were provided. About 100 physicians in each specialty evaluated services described by each vignette in terms of requirements of work, time, and intensity-- which consists of technical skill and physical effort-- mental effort, and

stress due to risk. During this phase of the study, only 372 unique services were examined through the survey. (Department of Health and Human Services, 1991, p. 33)

An outcome of phase one was the development of an extrapolation technique that could be used for developing the Relative Value Units (RVUs) for additional services. Prior to the close of phase one, the Harvard team, using the extrapolation technique, developed Relative Value Units (RVUs) for physician work for an additional 1400 services (Department of Health and Human Services, 1991, p. 33). The extrapolation methods used in phase one met with criticism from the medical community upon their release (Department of Health and Human Services, 1991, pp. 33-34).

Phase two of the study was used to develop additional Relative Value Unit (RVU) values, and to address medical community concerns over the validity of the extrapolation technique (Department of Health and Human Services, 1991, pp. 33-34). Phase 2 included an investigation of approximately fourteen new areas as well as a resurvey of three areas covered under phase one of the study. It was during phase two that organizations external to the government began to take a more aggressive role in the Relative Value Unit (RVU) development process by funding additional surveys in areas such as dermatology, ophthalmology, pathology, and psychiatry (Department of Health and Human Services, 1991, pp. 33-34).

In addition to resolving many of the concerns raised regarding phase one results, one of the outcomes of phase two was the development of a method for determining Relative Value Unit (RVU) values using a small panel of physicians. In phase

2, this “small group” method was used to determine Relative Value Unit (RVU) values for services not developed in the phase one survey. During phase 2 researchers found that a well-organized structured panel consisting of 11 to 14 physicians in a specialty could produce estimates of work that are “quite similar” to the survey estimates (Department of Health and Human Services, 1991).

An outcome of phase 3 of the study was the use of the physician panel or “small group process” to develop values for Current Procedure Terminology (CPT) codes that had not yet been assigned Relative Value Units (RVUs). Additionally, phase 3 utilized the small group process to develop Relative Value Units (RVUs) for procedures that had previously been developed using the extrapolation technique developed in phase 1.

The development of practice and malpractice expense Relative Value Units (RVUs) was accomplished in a manner different from that used for physician expenses. Practice expense and malpractice Relative Value Units (RVUs) instead were developed using historical data, as required by law. The Omnibus Budget Reconciliation Acts (OBRA) of 1989 and 1990 prescribed that the Secretary of Health and Human Services (HHS) compute practice expense and malpractice Relative Value Units (RVUs) by applying historical practice cost percentage data to an allowed base charge for each service. Physician expense Relative Value Units (RVUs) relied on an estimate of physician resources employed to provide a service. (Department of Health and Human Services, 1991, p. 52).

This legislation further required the Secretary of Health and Human Services (HHS) to review the relative values for physician services at a minimum of every five

years. The Secretary is also directed to “adjust the number of Relative Value Units (RVUs) to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures”(Department of Health and Human Services, 1991, p. 55). Changes made to the Relative Value Units (RVUs) must be published and accompanied by an explanation justifying the change. (Health and Human Services, 1991, p. 55)

Congress did build a fiscal “fail-safe” mechanism into this law to protect against significant cost growth as a result of the Relative Value Units (RVUs) review and revision process. Although not likely to be necessary, this mechanism furnishes providers with a measure of protection against downward adjustments in program costs as well. Specifically, the law requires, in part, that adjustments made as a result of the review process may not cause Supplementary Medical Insurance (SMI) expenditures to “differ by more than \$20 million from the expenditures that would have been made” had the adjustment not occurred (Department of Health and Human Services, 1991, p. 55).

(2) Geographic Adjustment Factors (GAFs). The second component of the Medicare Fee Schedule (MFS) is the set of Geographic Adjustment Factors (GAFs). The Geographic Adjustment Factors (GAFs) are, by definition, weighted averages of the individual Geographic Practice Cost Indexes (GPCIs) for each of the three Relative Value Unit (RVU) components -- physician work, nonphysician practice expense (exclusive of malpractice), and malpractice (Department of Health and Human Services, 1991, p. 58). The Geographic Adjustment Factors (GAFs) are used to measure the differences in the cost of

providing care in each of these three categories based on geographical differences. Required by section 1848(e) of the Omnibus Budget Reconciliation Act (OBRA) 1990 to develop the Geographic Adjustment Factors (GAFs), the Department of Health and Human Services (HHS) elected to contract with the Urban Institute (UI) and the Center for Health Economics Research (CHER) for Geographic Adjustment Factor (GAF) development.

With regard to the development of the Geographic Practice Cost Indexes (GPCIs), the Omnibus Budget Reconciliation Act (OBRA) of 1990 afforded the administration some flexibility by not specifying the manner in which they were to be devised. But, as indicated in the 1991 Health Care Financing Administration's (HCFA) proposed rule set, apparent concern over the expense and time associated with developing the Geographic Practice Cost Indexes (GPCIs) seems to have motivated the administration to extract much of the appropriate data from existing sources (Department of Health and Human Services, 1991, pp. 58-62). When the necessary data was not readily available, the administration used the substitutes that most nearly approximated the resource that they sought to measure (Department of Health and Human Services, 1991, pp. 58-62).

The proposed rule for providing payment for physician services, Part 56 FR 25792, provides a summary of the key resources that were considered by the staff of the Health Care Financing Activity (HCFA) as they developed the Geographic Practice Cost Indexes (GPCIs). Specifically, salient factors used to develop the indexes were:

- Physician work: The average hourly earnings of workers, based on a 20 percent sample of 1980 census data, in professional specialty occupations (for example,

teachers and engineers) with five or more years of college. Adjustments were made to produce a standard occupational mix in each area. The actual reported earnings of physicians were not used to adjust geographical differences in fees because these fees are, in large part, the determinants of the earnings, that is, using physician earnings would be "circular."

- Employee wages: Wages of clerical workers, registered nurses, licensed practical nurses, and health technicians were also based on a 20 percent sample of 1980 census data.
- Rents: Apartment rental data produced annually by the U.S. Department of Housing and Urban Development were used because there were insufficient data on commercial rents.
- Malpractice: Premiums (1985 through 1986) for a "claims made" policy (that is, a policy that covers malpractice claims during the covered period) providing \$100,000/\$300,000 of coverage were used. Adjustments were made to incorporate the costs of \$1 million/\$3 million coverage and mandatory patient compensation fund requirements. In States with differential premiums among areas, the rate applicable in each area was used. Data were collected on premiums for physicians in three risk classes: Low-risk (general practitioners who do not do surgery), moderate-risk (general surgeons), and high-risk (orthopedic surgeons). A "Medicare-weighted" risk group premium was created according to the share of Medicare spending accounted for by each risk class.
- Medical equipment, supplies, and "other" expenses: The Urban Institute (UI) and the Center for Health Economics Research (CHER) assumed that this component is represented by a national market and costs do not vary appreciably among areas. This component's index is 1 for all areas, to indicate no variation from the national average.

Once the data had been collected and grouped according to classification (i.e., physicians' work, practice expense and malpractice costs), the associated geographic practice cost indexes (GPCIs) was derived using one of two methods. For physicians' work and malpractice expense a comparison was made between the collected data

for the locality and the national average. Using this information, an offset or cost index was identified that allowed for a system-wide normalization of costs. For the calculation of a practice expense index, variations in employee wages, office rent, office equipment and other miscellaneous resources were weighted and mathematically combined prior to comparison to the national average for the data. Based on the amount of variation present, the practice expense index for the area under consideration was defined.

Section 1848 (e)(1) of the Social Security Act of 1965 as amended by the Omnibus Budget Reconciliation Acts (OBRA's) of 1989 and 1990 requires the Secretary of Health and Human Services (HHS) to "review, and revise if necessary, the Geographic Practice Cost Indexes (GPCIs) at least every three years (Department of Health and Human Services, 1991). As with changes in Relative Value Units (RVUs), adjustments to the Geographic Practice Cost Indexes (GPCIs) are published in the Federal Register with the explanation for the change accompanying the announcement. (Health and Human Services, 1991, p. 62)

(3) The Conversion Factor (CF). The third and final component of the Medicare Fee Schedule (MFS) is the Conversion Factor (CF). The purpose of the Conversion Factor (CF) is to allow the resource based relative values for physician services to be converted into dollar payment amounts after application of the weighted geographic adjustment factors. The Conversion Factor (CF), as implied by the Medicare Fee Schedule (MFS) equation previously given in Figure 4, "is a single national value that must apply to all

services paid under the fee schedule"(Department of Health and Human Services, 1991, p. 62).

As specified in the Omnibus Budget Reconciliation Act (OBRA) of 1989 as amended by the Omnibus Budget Reconciliation Act (OBRA) of 1990, the initial value of the Conversion Factor (CF) was to provide a result that was budget neutral. That is, the Conversion Factor (CF) was to be determined so that had the fee schedule been applied during 1991 it would have resulted in the same level of aggregate payments as would be made under the Current, Prevailing and Reasonable (CPR) system (Department of Health and Human Services, 1991, p. 68).

The determination of an appropriate initial Conversion Factor (CF) value was both complex and fiscally critical (Department of Health and Human Services, 1991, pp. 68-74). Selection of an initial Conversion Factor (CF) that was too large would have locked in greater program costs than had existed prior to reform and violated the legal requirement for budget neutrality. Similarly, a Conversion Factor (CF) that was too small, in addition to violating law, would have locked in inequities in payment levels promised physicians by the government during development of the reform. Furthermore, the Medicare Volume Performance Standard (MVPS) update mechanism would have worked to perpetuate the error. There does not appear to be any provision in the law for reestablishing the Conversion Factor (CF) baseline at a later date.

Many variables had to be considered in developing the initial Conversion Factor (CF). Health and Human Services (HHS) reported that computation of

the budget neutral Conversion Factor (CF) required “predictions for CY 1991 with respect to: (1) Fees for each procedure in each area (adjusted by the Geographic Adjustment Factor (GAF)), consistent with the application of the transition provisions; and (2) the frequency with which each procedure is performed”(Department of Health and Human Services, 1991, p. 68). Behavioral effects on the part of physicians and beneficiaries also had to be estimated. The process of estimating the effect on volume and mix of services provided as a result of “both increases and decreases in payments for various services, standardization of coding and other policies” was described by Health and Human Services (HHS) to be complex (Department of Health and Human Services, 1991, p. 73).

The requirement for budget neutrality, as determined by the value of the Conversion Factor (CF), appears to have been specified only for the program’s introductory year. The rate at which the value of a procedure would be allowed to grow would then be determined by criteria specified in the Medicare Volume Performance Standard (MVPS). Note that although the Conversion Factor (CF) would allow payment levels to be calculated for all procedures which had been ranked in accordance with the Resource Based Relative Value Scale (RBRVS), those rates would not necessarily apply immediately. Only those services with a Current, Prevailing and Reasonable charge (CPR) within 15 percent of the Medicare Fee Schedule (MFS) value would be subject to the newly implemented rates during the introductory year. All other services would be paid in accordance with a four-year transition schedule that relied upon a combination of the Medicare Fee Schedule (MFS) and

Current, Prevailing and Reasonable (CPR) allowable charges. (Congressional Budget Office, 1990)

(4) MFS Implementation and Transition. The rules governing the four-year transition, 1992-1996, for the implementation of the Medicare Fee Schedule (MFS) were specified by the Omnibus Budget Reconciliation Act (OBRA) 1990 and set forth in law by section 1848(a)(2) of the Social Security Act. The transition period relies on a blend of Current, Prevailing and Reasonable (CPR) and corresponding Medicare Fee Schedule (MFS) rates for those services not covered under the Medicare Fee Schedule (MFS) during the introductory year. The decision regarding what blend of rates to apply to a particular procedure depends upon a comparison between the Medicare Fee Schedule (MFS) rate and a quantity termed the Historical Payment Basis (HPB) for a service. A Historic Payment Basis (HPB) was calculated for each service in each locality based primarily on 1991 prevailing charges, adjusted to reflect instances in which payment is less than the prevailing charge and conceptually is the average amount Medicare allows for each service in the locality for 1991, updated to 1992 (Congressional Budget Office, 1990). A general description of the transition schedule follows:

- 1992: (1) For procedures with a Historic Payment Basis (HPB) within 15 percent of the Medicare Fee Schedule (MFS) amount, payment for the service will be made at the rate specified under the Medicare Fee Schedule. (2) Allowed charges for remaining services will be determined based on a Constrained Medicare Fee Schedule (CMFS) amount as follows:

$CMFS = HPB - 15\% * MFS$ (for HPB values > MFS)

$CMFS = HPB + 15\% * MFS$ (for HPB values < MFS)

- 1993: After adjusting both the 1992 Constrained Medicare Fee Schedule (CMFS) and Medicare Fee Schedule rates in accordance with the Medicare Volume Performance Standards (MVPS), the Constrained Medicare Fee Schedule rate is calculated as follows:

$CMFS = (75\% * \text{Adjusted CMFS}_{1992}) + (25\% * \text{Adjusted MFS amount})$

- 1994: After adjusting both the 1993 Constrained Medicare Fee Schedule (CMFS) and Medicare Fee Schedule (MFS) amounts in accordance with the Medicare Volume Performance Standards (MVPS), the Constrained Medicare Fee Schedule (CMFS) rate is calculated as follows:

$CMFS = (67\% * \text{Adjusted CMFS}_{1993}) + (33\% * \text{Adjusted MFS amount})$

- 1995: After adjusting both the 1994 Constrained Medicare Fee Schedule (CMFS) and Medicare Fee Schedule (MFS) rates in accordance with the Medicare Volume Performance Standards (MVPS), the Constrained Medicare Fee Schedule (CMFS) is calculated as follows:

$CMFS = (50\% * \text{Adjusted CMFS}_{1994}) + (50\% * \text{Adjusted MFS amount})$

- 1996: Constrained Medicare Fee Schedule (CMFS) rates will no longer be calculated. Medicare Fee Schedule rates will be in effect for all services.

c. Maximum Allowable Actual Charge (MAAC)

Section 1848(g) of the Social Security Act, as determined by the Omnibus Budget Reconciliation Acts (OBRA) of 1989 and 1990, established a limit on the amount that nonparticipating physicians would be allowed to charge Medicare Part B beneficiaries. The purpose of the Maximum Allowable Actual Charge (MAAC) was to protect the Supplementary Medical Insurance (SMI) enrollees access to care after the implementation of

reform. The threat of higher balance billing levels by physicians who stood to lose fee revenue as a result of the Medicare Fee Schedule (MFS) and the Medicare Volume Performance Standard (MVPS) appears to have been the driving force for this portion of reform. (Grimaldi, 1991, p. 58)

Implementation of the Maximum Allowable Actual Charge (MAAC) was scheduled to take place over a three year period beginning in 1991. A summary of the transition schedule follows:

- 1991: The physician's actual charge may not exceed 125 percent of the Medicare fee;
- 1992: The physician's actual charge may not exceed 120 percent of the Medicare fee;
- 1993: The physician's actual charge may not exceed 115 percent of the Medicare fee.

C. SUMMARY

The Current, Prevailing and Reasonable (CPR) payment methodology, which had been used since the introduction of Medicare, had “one overriding goal in mind: assuring physician participation in a program whose passage had been vehemently opposed by the profession” (Epstein and Blumenthal, 1993, p. 193). Although successful in encouraging physician participation, over time the Current, Prevailing and Reasonable (CPR) methodology came to be perceived as providing inappropriate incentives which contributed to “uncontrolled growth in the cost of physician services” (Epstein and Blumenthal, 1993, p. 193). Under increased

scrutiny as a result of growth in program costs during the seventies and eighties, these incentives came to be identified as contributing to the growth in program expenditures. (Epstein and Blumenthal, 1993, p. 193)

Cave and Vidovic have indicated that the Current, Prevailing and Reasonable (CPR) methodology “came under scrutiny because of its inflationary nature” (Cave and Vidovic, 1991, p. 24). Characterized in this manner, its practice of rewarding physicians based on past charges was viewed as providing an incentive for practitioners to raise their fees with the goal of obtaining higher future customary charges. The Current, Prevailing and Reasonable (CPR) payment method was also identified by Lee and Mitchell (Lee and Mitchell, 1994, p. 65) as a device that locked-in inequities between procedures and treatments. From this perspective the Current, Prevailing and Reasonable (CPR) methodology was characterized as having a tendency to “overvalue procedural services . . . undervalue maintenance services and consultations . . . and to encourage physicians to provide care using more elaborate and expensive practice systems”(Cave and Vidovic, 1991, p. 24). Furthermore, the incentive structure created by the Current, Prevailing and Reasonable (CPR) payment method was also credited with reductions in the quality of care by encouraging the provision of inappropriate and less effective procedures (Congressional Budget Office, 1986, pp. 30-33).

The physician reform specified in the Omnibus Budget Reconciliation Acts (OBRA) of 1989 and 1990 was designed as a response to uncontrolled growth in Supplementary Medical Insurance (SMI) costs and concerns over quality and access to care. Its three major mechanisms for achieving change were the Medicare Volume Performance Standard (MVPS),

the Medicare Fee Schedule (MFS), and the Maximum Allowable Actual Charge (MAAC) rules. The Medicare Volume Performance Standard (MVPS) functions as the primary mechanism for controlling the rate at which Supplementary Medical Insurance (SMI) expenditures would be allowed to grow. The Medicare Fee Schedule (MFS) was enacted to correct inappropriate incentives that existed as a result of the Current, Prevailing and Reasonable (CPR) method of payment. The last mechanism, the Maximum Allowable Acceptable Charge (MAAC), functions to ensure continued access to care by eliminating financial barriers that might arise should physicians, faced with recovering less from Medicare, choose to shift the financial burden to recipients in the form of balance billing.(Lee, 1990, p. 277)

Chapter III examines the environment leading to the introduction of these three major mechanisms from the institutional and resource dependence perspectives. The goal of Chapter III is to develop a greater level of understanding of the decision making process that prompted the reform effort. The Medicare Fee Schedule (MFS), Medicare Volume Performance Standard (MVPS) and the Maximum Allowable Actual Charge (MAAC) are revisited in Chapters IV and V where the institutional and resource dependency theories are used to develop models to assist in explaining the probable outcome of the reform effort.

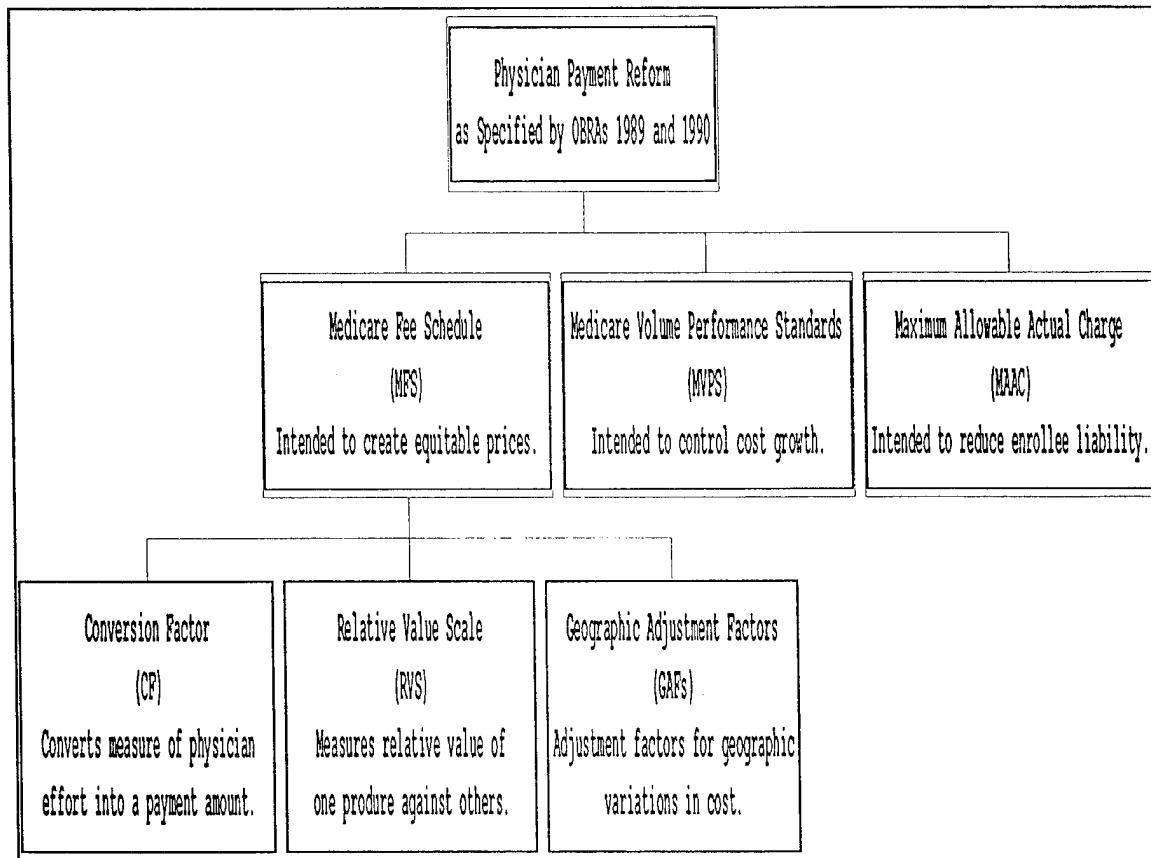


Figure 22. Major Reform Mechanisms and Associated Key Components.

$$UF_{CY+1} = MEI_{CY+1} - (AG_{CY-1} - DT_{CY-1})$$

where:

UF_{CY+1} = Update Factor for upcoming year

MEI_{CY+1} = Projected MEI for upcoming year

AG_{CY-1} = Actual growth in Medicare expenditures
for the previous year

DT_{CY-1} = Default Target for the previous year

Note: CY = Current Year

Figure 23. Methodology for Determination of the Default Update Factor.

Assumptions:

- Projected Medicare Economic Index (MEI_{CY+1}): 5%
- Default Target (DT_{CY-1}): 11%
- Actual Growth in Medicare physician expenditures (AG_{CY-1}): 14%

Calculation of Default Update Factor:

$$\begin{aligned} \bullet UF_{CY+1} &= MEI_{CY+1} - (AG_{CY-1} - DT_{CY-1}) \\ &= 5\% - (14\% - 11\%) \\ &= 2\% \end{aligned}$$

Figure 24. Default Target Method Sample Calculation.

$$MFS_S = [(RVUw S * GPCIw A) + (RVUp S * GPCIpe A) + (RVUm S * GPCIm A)] * CF$$

where:

RVUw S=	Physician work relative value units for service S.
RVUp S=	Practice expense relative value units for service S.
RVUm S=	Malpractice relative value units for service S.
GPCIw A=	Geographic Practice Cost Index for physician work in area A.
GPCIpe A=	Geographic Practice Cost Index for practice expense in area A.
GPCIm A=	Geographic Practice Cost Index for malpractice expense in area A.
CF=	Conversion Factor as established by the Secretary of Health and Human Services.

Figure 25. Methodology of the Medicare Fee Schedule.

III. FRAMEWORK FOR REFORM ANALYSIS

This chapter provides an overview of the institutional and resource dependence theories of organizational behavior. Chosen for their utility in providing insight into the way an organization is affected by its environment, these theories or perspectives provide the context under which the Medicare Fee Schedule (MFS) is examined in Chapters IV and V. The discussion of these theories is not intended to be comprehensive. Only the features of the institutional and resource dependency theories that are employed in this analysis are provided. For sources of additional information regarding these theories the reader is referred to the bibliography.

A. INSTITUTIONAL AND RESOURCE DEPENDENCY THEORIES: COMMON ASSERTIONS

Although the institutional and resource dependency theories offer different perspectives to understand organizational behavior, they do share a number of common assertions. Included in these assertions are that: a) organizations function as open systems (Scott, 1992, p. 25), b) organizational forms are influenced by the organization's relationship with its environment (Scott, 1992, p. 132), and c) organizations are viewed primarily from the natural system perspective (Scott, 1992, pp. 24-25).

1. Open System Nature of Organizations

Perhaps one of the more concise definitions of an open system is that offered in Boulding's (Boulding, 1956) classification of system types. In his hierarchy of systems

Boulding describes an open system as one “capable of self-maintenance based on a throughput of resources from its environment, such as a living cell”(Boulding, 1956, p. 203). As Boulding’s definition suggests, the open system perspective argues that organizations are not autonomous entities but instead remain dependent upon their environments for the resources that they require in order to survive.

In contrast, a closed system is one that does not rely upon an exchange with its environment to remain viable. It is “separate from its environment and comprised of a set of stable and easily identified participants” (Scott, 1981, p. 22). By comparing these definitions it may be seen that the classification of a system as open or closed is somewhat subjective in that it is dependent upon where the observer draws system boundaries. Specifically, as stated by Hall and Fagen, “whether a given system is open or closed depends on how much of the universe is included in the system and how much in the environment” (Hall and Fagen, 1956, pp. 18-28).

2. Organizations as Products of Their Environments

In both the institutional and resource dependency theories the environment is accepted as a primary factor in the determination and maintenance of organizational form. This acceptance is illustrated by viewpoints conveyed by Brint and Karabel (1991, pp. 337-360) and by Pfeffer and Salancik (1978).

From the institutional perspective Brint and Karabel reaffirm “the idea that organizations, much like biological species, ‘adapt’ to their environments” . . . and that organizations “survive if they fit into niches in the ecology of existing organizations” (Brint

and Karabel, 1991, pp. 348-349). Pfeffer and Salancik divide the environment into two dimensions, the enacted and unheeded and maintain that, with regard to the resource dependency perspective, “although organizational decisions are determined by the enacted environment . . . organizational outcomes can (also) be affected by parts of the environment not noticed or heeded” (Pfeffer and Salancik, 1978). This argument differs from that presented by the rational perspective. (Scott, 1992)

From the rational perspective organizational structures are viewed as functional in nature (Scott, 1992, pp. 29-50). The rational perspective holds that organizational structures are determined internally with the specific intent of coordinating and supporting organizational components in the conduct of the mission of the organizations (Scott, 1992, pp. 29-30).

Although the institutional and resource dependency theories agree that the environment is the fundamental influence for determining organizational structure, they differ in their view of the manner in which the process takes place (Zucker, 1977, pp. 726-745). Fundamentally, institutional theory argues that organizational structures are concerned primarily with survival and that their opportunities for success increase as they acquire legitimacy (DiMaggio, 1988, p. 3). Legitimacy is important to an organization because, as stated by Meyer and Scott (Meyer and Scott, 1983, p. 201), “organizational legitimacy refers to the degree of cultural support for an organization”. Furthermore, “organizations that incorporate societally legitimated rationalized elements in their formal structures maximize

their legitimacy and increase their resources and survival capabilities” (Meyer and Rowan, 1992, p. 34).

Resource dependency theory, however, views organizational structure as an outcome of the organization’s effort to adapt to influences communicated through linkages with its environment (Scott, 1992). Resource dependency, as its name implies, considers the effective management of these environmental linkages as the key to ensuring organizational survival. Furthermore, resource dependency theory suggests that in dense organizational networks, such as those found in political environments, that “interests become entwined and interconnected” (Pfeffer and Salancik, 1978, p. 188). Specifically, in a political environment, Pfeffer and Salancik suggest that “the feasibility of coordinating interests, under such circumstances diminishes, and the possibility of absorbing all the necessary interdependencies disappears completely” (Pfeffer and Salancik, 1978, p. 188). These concepts will be more fully developed in the discussion of the theories that follows.

3. Natural System Perspective

Two qualities that are present in most organizations may be associated with the rational and natural systems perspectives. The rational systems perspective holds that “an organization is a collectivity oriented to the pursuit of relatively specific goals and exhibiting a relatively highly formalized social structure” (Scott, 1981, p. 20). Conversely, the natural system perspective views an organization as “a collectivity whose participants are little affected by the formal structure or official goals but who share a common interest in the

survival of the system and who engage in collective activities, informally structured, to secure this end” (Scott, 1981, p. 22).

Institutional and resource dependency theories argue that in organizations the natural system perspective assumes a dominant role over behavior suggested by the rational perspective. As observed by Selznick, formal structures cannot overcome the importance of behavior that from an economic perspective is not strictly rational. (Selznick, 1948).

B. INSTITUTIONAL THEORY

Institutional theory suggests that “organizations are created by the development and elaboration of institutional rules and beliefs as well as by structural or relational complexities” (Scott, 1981, p. 141). Although this theory recognizes that organizations are a product of both institutional and rational factors, it holds that the institutional rules and beliefs or “rationalized myths” present in the environment are the dominant force that determines and maintains the structure of the organization (Meyer and Rowan, 1983, p. 148).

Institutional organizations are unlike rational organizations which are task specific and may be disassembled upon task completion. Instead, the very nature of institutionalization “deals with the persistence and perpetuation of activity” (Pfeffer, 1982, p. 239). Therefore, the organization adheres to rationalized myths present in the environment because the myths communicate the standard to which the organization must conform in order to acquire legitimacy and increase its potential for survival.

An organization’s conformance to that specified by the environment is known as institutional isomorphism. The manner in which isomorphism comes to be and the factors that

influence organizational success are presented in Meyer and Rowan's (Meyer and Rowan, 1978, p. 353) model describing organizational survival. The model is given in Figure 26.

The process embodied in the model begins with the elaboration of rationalized institutional myths in the organization's environment. Organizations seeking to survive must achieve conformity with the rationalized institutional myths present in its environment. Conformity allows the organization seeking survival to "become legitimated by environmental institutions" (Meyer and Rowan, 1978, p. 352). Legitimacy in turn allows the organization to acquire the scarce resources needed for survival. Key concepts associated with the Organizational Survival Model are discussed in greater detail as follows:

a. Legitimacy

As suggested by Pfeffer and Salancik, "legitimacy is bound up with social norms and values; and while it is not correlated perfectly with either law or economic viability, it bears some relationship to both" (Pfeffer and Salancik, 1978, p. 193). The relationship depicted in Figure 26 demonstrates that in addition to scarce resources, the acquisition of legitimacy is also critical to organizational survival. It follows then that an organization, in its effort to maximize its survival potential, will adopt an organizational structure and practices that are consistent with those norms and values being signaled by its environment. This behavior further implies that legitimacy is generally recognized by organizations as an externally conferred status which is commonly believed to be retrospective in nature. It is an external quality because it is bestowed on an organization not from within but by its environment. Also, legitimacy, viewed as a retrospective quality,

“implies that an organization reviews its past actions and outputs in the context of current societal values and interests” (Pfeffer and Salancik, 1978, pp. 194-195).

b. Isomorphic Processes

Within the context of institutional theory, isomorphism refers to the trend toward structural similarity between organizations in an environment. It is assumed in institutional theory that an organization responds to environmental signals regarding legitimate behavior by adapting its organizational structure and policies to conform to societal myths and symbols in order to maximize its prospect for survival (DiMaggio and Powell, 1991). It follows then that a population of organizations existing within an environment and conforming to the same signals should adopt similar structures and policies. Institutional theory proposes that this isomorphic process may take place in one or a combination of three ways, coercively, mimetically or normatively (DiMaggio and Powell, 1991, p. 67).

(1) Coercive Isomorphism. As its name implies “coercive isomorphism results from both formal and informal pressures exerted on organizations by others in the environment upon which the focal organization is dependent and by cultural expectations in the society within which organizations function” (DiMaggio and Powell, 1991, p. 67). Examples of environmental influence measures that contribute to coercive isomorphism include the imposition of legislatively mandated programs, economic inducements by community and other special interest groups, and societally implied requirements for an organization to act to sustain its legitimate status.(DiMaggio and Powell, 1991, p. 67)

(2) Mimetic Isomorphism. Mimetic isomorphism may result when an organization is faced with environmental uncertainty.(DiMaggio and Powell, 1991) Specifically, when an organization does not understand changes taking place in its environment it may choose to adopt a structure and policies similar to those being used by other organizations elsewhere in the environment. By choosing to adopt structures and policies that it perceives as successful it is able to mitigate its risk relative to other organizations present in the environment.(DiMaggio and Powell, 1991) For example, many U.S. industrial organizations responded in this manner in the late eighties when Japanese industry began to increase its market share in industries such as automobile manufacturing and electronics. Sensing the need to act as a result of eroding market shares, but not fully understanding the reasons for Japanese success, U.S. automobile and electronics manufacturers responded by implementing programs such as Total Quality Management and by modifying their organizations and practices in ways that mimicked their relatively more successful competitors.

(3) Normative Isomorphism. Normative isomorphism results from pressure being exerted as a result of environmental standardization and professionalization.(DiMaggio and Powell, 1991, pp. 70-74) Both of these processes define a range of behaviors and practices a society will accept as legitimate. Federal, state, and coalition-sponsored programs for professional registration and licensing lead to normative isomorphic behavior on the part of organizations and individuals.(DiMaggio and Powell, 1991, pp. 70-74) Because of normative isomorphism hospitals require that doctors possess

certain minimum credentials before they are allowed to practice. Similarly, before being accepted by an environment as legitimate, lawyers must pass the bar examination, engineers must complete the professional registration process and members of trades, such as electricians, must be licensed. Consequently, organizations seeking to maintain their legitimacy will be likely to employ only those individuals who have satisfied the requirements prescribed by professions and standards accepted by the environment.(DiMaggio and Powell, 1991, pp. 73-74)

c. *Six Propositions Describing Institutional Behavior*

Although this analysis makes use of many aspects of institutional theory, it makes frequent reference to Meyer and Rowan's (Meyer and Rowan, 1978, pp. 345-359) six propositions for examining the emergence and behaviors of organizations as institutions within an environment . The proposals are as follows:

- Proposition 1. As rationalized institutional rules arise in given domains of work activity, formal organizations form and expand by incorporating these rules as structural elements.
- Proposition 2. The more modernized the society, the more extended the rationalized institutional structure in given domains and the greater the number of domains containing rationalized institutions.
- Proposition 3. Organizations that incorporate societally legitimated rationalized elements in their formal structures maximize their legitimacy and increase their resources and survival capabilities.
- Proposition 4. Because attempts to control and coordinate activities in institutionalized organizations lead to conflicts and loss of legitimacy, elements of structure are decoupled from activities and from each other.

- Proposition 5. The more an organization's structure is derived from institutionalized myths, the more it maintains elaborate displays of confidence, satisfaction, and good faith, internally and externally.
- Proposition 6. Institutionalized organizations seek to minimize inspection and evaluation by both internal managers and external constituents.

C. RESOURCE DEPENDENCY THEORY

1. General Description

As described by Pfeffer, “resource dependency theory suggests that organizational behavior becomes externally influenced because the focal organization must attend to the demands of those in its environment that provide resources necessary and important for its continued survival” (Pfeffer, 1982, p. 193). In addition to considering the constraints imposed on an organization by its environmental links, resource dependency also places value on examining the manner in which internal organizational decision making impacts the organization’s ability to adapt to its environment. Although both internal and external factors are considered important to the resource dependency perspective, the dominant influence in determining organizational form and procedure will be that originating in the environment. In this manner the organizational form is determined when key internal decision makers, responding to the external stimuli, craft an organizational form capable of managing the environmental linkages.

The context suggested by resource dependency theory may be understood by considering the properties of an organizations as seen from the open system perspective. In an open system there are no organizations that exist in a purely autonomous state.

Consequently, an organization must depend, to various degrees, on the relationships that exist between itself and the suppliers of scarce resources and consumers of the organization's output for its continued survival. The linkages suggested by these dependencies provide the basis for the political, business and social relationships that must be managed for the focal organizations to succeed.

Resource dependency suggests that an organization will seek to manage environmental relationships by minimizing dependence on them and thus mitigating threats to its survival. The management of these dependencies is viewed as being accomplished by using internal and external coalitions.

2. Importance of Individuals in Effecting Change

Resource dependency theory suggests that individuals within an organization will "attempt to manage their external dependencies, both to ensure the survival of the organization and to acquire, if possible, more autonomy and freedom from external constraint" (Pfeffer, 1983, p. 193). There are primarily two ways in which individuals act to effect change in an organization: 1) as managers or key decision makers and 2) as internal coalitions.

a. Role of Management

(1) Management's Symbolic Capacity. Resource dependency views managers as having a relatively important role in an organization. First, managers are seen as having a symbolic dimension. This perspective proposes that the manager is "a symbol of the organization and its success or failure, a scapegoat, and a symbol of personal or individual

control over social actions and outcomes" (Pfeffer and Salancik, 1978, p. 263). In this capacity organizations are given the appearance of being under the control of individuals, a condition that other dimensions of resource dependency indicate is unlikely to exist to a significant extent.

In addition to the symbolic capacity of management, the rituals and ceremonies employed when changes are effected in the management team are also important to the organization. For example, devices such as installation ceremonies are used to facilitate public acceptance of the individual.

The utility of managers from this perspective lies not in their ability to directly effect organizational changes but in the rituals and symbols associated with their office. As suggested by Pfeffer and Salancik, "important social functions are served by the manipulation of symbols" (Pfeffer and Salancik, 1978, p. 17). For example, the need for change in an organization may be signaled by the replacement of a key management official. Similarly, personal traits that the organization seeks to reinforce may be communicated by offering a meritorious promotion to an individual demonstrating those traits.

(2) Management's Active Role. In addition to their symbolic role management is also viewed by resource dependency theory as having an active quality. Managers, in an active sense, are considered as having utility because of their ability to: 1) take action to influence the conditions of the organization's environment and 2) serve the organization by making a determination of the actual state of the existing environment.

Resource dependency theory recognizes that many of the constraints encountered by an organization do not occur naturally in its environment. That is, many of the constraints that exist are the product of coalitions gaining the requisite social support needed to put the constraint in place. Because this type of constraint is a social construct, it follows that managers may be able to act on behalf of the organization by gaining support for removing or modifying the constraint. In this capacity management is able to work actively toward the successful management of the influence measure be it internal or external in nature.

The second function of managerial action contained within this perspective is that of recognizing the social context in which the organization exists. This is a prerequisite to the organization's effort of managing the power relationship inherent in its linkages to its environment. In this capacity management must not only focus on those issues related to obtaining physical resources but they also must seek to be aware of power relationships existing within a social context.

b. Role of Individuals

Individuals in an organization provide the building blocks of the internal coalitions that must form in order to effect the change required by an organization as it seeks to adapt to disturbances in its environment. Coalitions are the mechanisms for achieving change in an organization. As suggested by Thompson (1967), it is the dominant coalition in an organization that is the body that determines the "official" direction of the organization. The process of forming and maintaining a dominant coalition is "a dynamic one, subject to

perturbation and change” where “even in the most bureaucratic organizations there is an “undercurrent of bargaining, jockeying for position, and alliance formation that creates potential for change regardless of the organization’s official strategy and stated position” (Kanter, et al., 1992, p. 47) This process of internal influence is also described by Pfeffer and Salancik in that, “organizations, in addition to being coalitions of interests, are markets in which influence and control are transacted” (Pfeffer and Salancik, 1978, p. 259).

Although individuals are important influences on organizational behavior, resource dependency theory holds that their impact is generally considered to be less dominant than environmental effects. Pfeffer and Salancik attribute this quality to contributions from three factors: 1) effects caused by the leadership selection process, 2) individual discretionary limitations and 3) the occurrence of events beyond the control of the individual (Pfeffer and Salancik, 1978, pp. 6-10).

The manner in which organizational policies and leader select individuals for promotion tends to lead to a homogeneous set of skills in the organization’s body of key decision makers. It is this homogeneity that may result in loss of breadth and diversity in organizational leadership skills. As a result, management’s range of possible responses to changing environmental conditions is likely to become constrained relative to a leadership chosen for their broad range of style, skills and perspectives. (Pfeffer and Salancik, 1978)

Individual discretionary limitations must be considered when examining the role of the individual in effecting organizational change. Constraints on the ability of individuals to exert their will are encountered at all levels in an organization. Even when

individuals achieve high level positions there are still limitations placed on their discretion to act. For example, politicians must answer to their constituency just as chief executive officers must answer to shareholders. Limitations on discretion may take on formal and informal constraints. Formal limitations may be achieved through measures such as the implementation of rigid bureaucratic requirements while informal limitations may take less obvious forms.

(Pfeffer and Salancik, 1978)

The ability of an individual to effect change may also be limited by actions taking place in the environment that are beyond that individual's control. Factors such as the effects of material shortages, acts of God, and labor strikes at supplier operations are all examples of environmental effects that individual action may not be able to mitigate. Internally, individuals serving as managers may find that though issues such as a subordinate employee or coworker's general health, state of mind, or mood may have an impact on operations, they, as managers, have little control over their occurrence or outcome. (Pfeffer and Salancik, 1978)

3. The Environment: A Contextual Perspective

Resource dependency theory argues that the dominant influences that determine what form and policies an organization is likely to adopt are determined by internal responses to stimuli originating in the environment. This section examines the nature of these influence measures as they relate to organizational effectiveness, efficiency, sensitivity and internal and external constraints.

a. Effectiveness and Efficiency

Assuming that the survival of an organization is important to its members, the manner in which it chooses to adapt to change is critical to the likelihood of its success. As stated by Pfeffer and Salancik, “survival comes when the organization adjusts to, and copes with, its environment, not only when it makes efficient internal adjustments” (Pfeffer and Salancik, 1978, p. 11). This point alludes to the importance of being able to distinguish between the differences in these two concepts.

Effectiveness is generally viewed as an external measure of the quality of an organization’s response to its environment. It is a concept that considers not only how well the organization is pursuing a particular task but also whether the task is an appropriate course of action for the organization. (Pfeffer and Salancik, 1978)

Efficiency is taken to be an internal measure. It considers how well the organization is carrying out a particular task or set of tasks. It is important to note that efficiency does not consider whether the course of action being undertaken by an organization is appropriate but only whether the output being produced justifies the quantity of resources being consumed. (Pfeffer and Salancik, 1978)

From a resource dependency perspective, the organization that has the greatest likelihood of succeeding is the one that responds to external influences in a manner consistent with the concept of effectiveness. That is, the preferred action calls for choosing an adaptation strategy that considers the usefulness of actions being taken in the context of the

environment rather than relying solely on how well internal activities are being conducted.

(Pfeffer and Salancik, 1978)

b. Organizational Sensitivity

Effective management of the links that tie an organization to its environment, in the context previously presented, is very important to an organization's effort to continue to survive. Although resource dependency theory stresses the importance of responding to the demands of the environment, it also addresses the need for an organization to appropriately sensitize itself to its environment. The frequency and intensity of the various stimuli received from the environment may be continuous, diverse and potentially conflicting. Responding to every stimuli could result in a very unstable organizational structure.

Instead, organizations might benefit by adopting practices that would allow them to filter out some of the external influences. Guidelines describing the manner in which this may be accomplished are suggested by Pfeffer and Salancik. They describe ten conditions that affect the extent to which an organization would comply with external demands (Pfeffer and Salancik, 1978, p. 44). They are as follows:

- The focal organization is aware of the demands.
- The focal organization obtains some resources from the social actor making the demands.
- The resource is a critical or important part of the focal organization's operations.
- The social actor controls the allocation, access, or use of the resource; alternative sources for the resource are not available to the focal organization.

- The focal organization does not control the allocation, access, or use of other resources critical to the social actor's operation and survival.
- The actions or outputs of the focal organization are visible and can be assessed by the social actor to judge whether the actions comply with its demands.
- The focal organization's satisfaction of the social actor's requests is not in conflict with the satisfaction of demands from other components of the environment which its is interdependent.
- The focal organization does not control the determination, formulation, or expression of the social actor's demands.
- The focal organization is capable of developing actions or outcomes that will satisfy the external demands.
- The focal organization desires to survive.

Without adopting an appropriate level of sensitivity, an organization would be likely to find itself in a perpetually reactive state instead of focusing on actions that contribute to long-term effectiveness. Organizations may employ numerous measures to allow them to filter the effects of the environment. Many of the most readily observable involve some form of structurally adaptive response. For example, a congressman may surround herself or himself with layers of staff assistants and require that they deal with routine issues and divert those of little consequence.

In addition to considering the appropriate level of environmental sensitivity, the organization must select the practices it will use to perceive and interpret its environment. This choice is important because reality from a resource dependency perspective is taken to

be subjective in nature. Consequently, the what, where, why and how of gathering environmental information becomes significant undertakings.

c. Internal and External Constraints

Constraints are defined by Pfeffer and Salancik as conditions in the environment that ensure that responses to a situation are not random (Pfeffer and Salancik, 1978, p. 15). Though often perceived as an impediment to exercising free will, constraints may also provide the organization with direction.

Internally, constraints may be designed to guide action and decision making in a manner that supports the organization's effectiveness strategy. Externally, the organization may look to a number of constraints as guideposts for determining the range of acceptable behavior within its environment.

D. SUMMARY

Because of the importance of legitimacy and the organizational environment to political organizations, the institutional and resource dependency theories are able to provide significant insight regarding the manner in which they behave. Using these theories Chapters IV and V examine the roles of Congress and other appropriate government organizations as they relate to physician payment reform as specified in the Omnibus Budget Reconciliation Acts (OBRA) of 1989 and 1990.

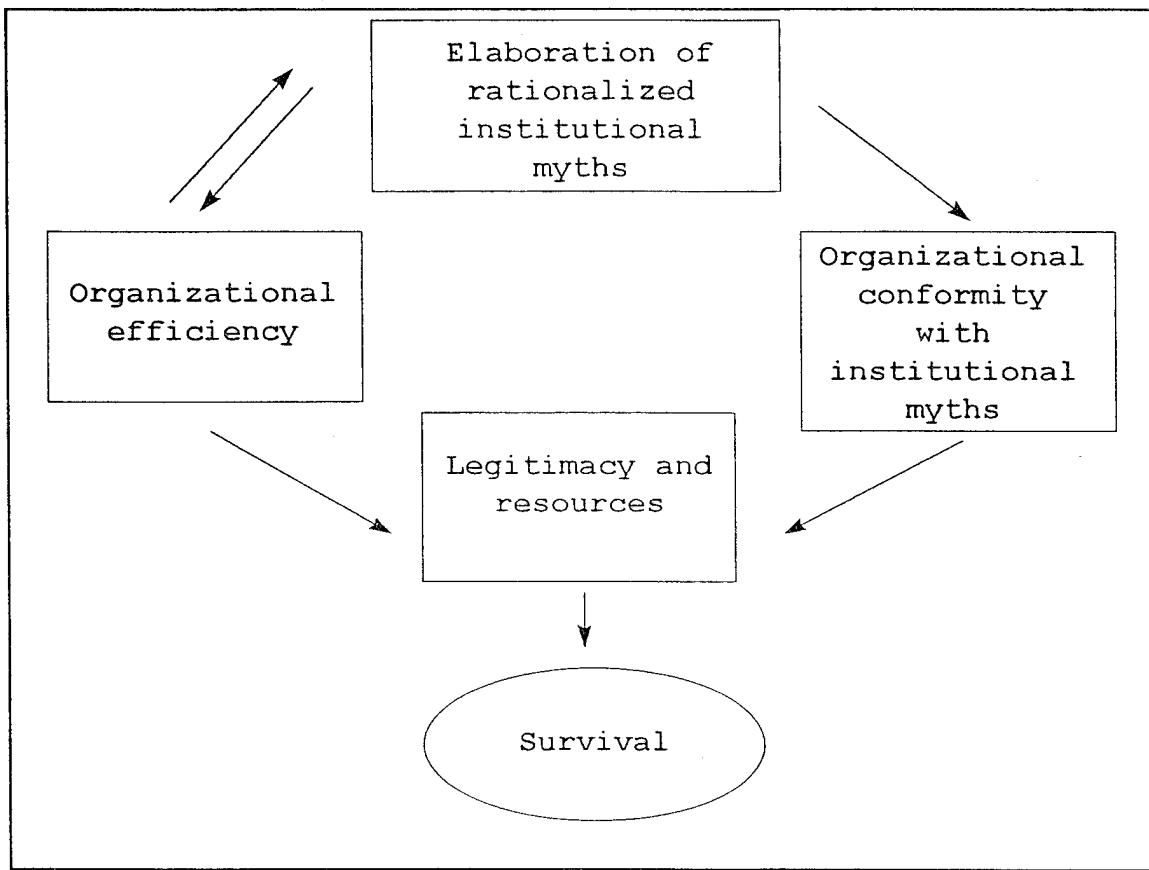


Figure 26. Meyer and Rowan's Organizational Survival Model. (Meyer and Rowan, 1978, p. 353)

IV. REFORM ANALYSIS- THE ORGANIZATIONAL ENVIRONMENT

As a policy, the Medicare Fee Schedule (MFS)-- a mandate by Congress, its development influenced by many organizations, and its execution dependent upon the Department of Health and Human Services (DHHS)-- does not lend itself directly to analysis using the tools offered by organizational theory. Consequently, an institutional and resource dependency examination of policies and actions resulting from the implementation of the Medicare Fee Schedule (MFS) must be conducted relative to some focal organization. The focal organization selected for use in this analysis is the Department of Health and Human Services (DHHS).

This analysis begins with a description of the focal organization, the Department of Health and Human Services (DHHS) and its subordinate agency, the Health Care Financing Administration (HCFA). A model of the Health and Human Services (HHS) environment is then introduced, identifying and describing organizations that have taken an active role in health care reform. Following this model, the concept of hyperpluralism is introduced and related to the organizations active in physician payment reform. The chapter concludes with a chronology of salient events in the development and implementation of physician payment reform, with emphasis on the interaction between the Department of Health and Human Services (DHHS) and organizations present in its environment. In the next chapter, the institutional and resource dependency theories are applied to events described in the

chronology in order to gain an understanding of issues and actions associated with physician payment reform.

A. FOCAL ORGANIZATION

The Department of Health and Human Services (DHHS) is an executive agency within the federal government. It describes itself as "the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves" (Department of Health and Human Services, 1995, World Wide Web Home Page).

The Department comprises four operating divisions: 1) the U.S. Public Health Service, 2) the Administration for Children and Families, 3) the Administration on Aging and 4) the Health Care Financing Administration (HCFA). The Health Care Financing Administration (HCFA) plays the predominant role in the administration of the Medicare program.

The Health Care Financing Administration (HCFA) was established on March 8, 1977, approximately eleven years after the introduction of Medicare. The purpose of creating this agency was "to combine under one administration the oversight of the Medicare program and related quality assurance activities"(Department of Health and Human Services, 1995, World Wide Web Home Page). In fiscal year 1993, the Health Care Financing Administration (HCFA) served "67 million people, or one in four elderly, disabled and poor Americans through Medicare and Medicaid"(Department of Health and Human Services, 1995, World Wide Web Home Page).

An additional dimension of understanding the Health Care Financing Administration (HCFA) may be gained by considering its organizational mission statement and vision for the future. In part, the Health Care Financing Administration (HCFA) has articulated its organizational role as follows:

We [HCFA] assure health care security for beneficiaries. Health security means: 1) Access to affordable and quality health care services; 2) Protection of the rights and dignity of beneficiaries; and, 3) Provision of clear and useful information to beneficiaries and providers to assist them in making health care decisions" (Department of Health and Human Services, 1995, World Wide Web Home Page).

Addressing the future of the organization, the Health Care Financing Administration (HCFA) vision statement

. . . reflects our (HCFA's) commitment that: 1) All individuals will be given an unconditional assurance of having the same opportunity to have their health care needs met, regardless of location, income, or other circumstances; and 2) The quality of health care they receive is the best that can be provided."(Department of Health and Human Services, 1995, World Wide Web Home Page)

B. COMPONENTS OF THE FOCAL ORGANIZATION ENVIRONMENT

A review of the literature indicates that a number of organizations were active in physician payment reform. Consequently, the organizations selected for inclusion into the model of the Department of Health and Human Services (DHHS) organizational environment is not comprehensive but intended to give the reader an appreciation for the number and diversity of those active in payment reform.

The environment surrounding the Department of Health and Human Services (DHHS) may be depicted graphically in the manner suggested by Bryson's Stakeholder Map for a Government (Bryson, 1988, p. 102). Bryson's model is presented in Figure 27.

An adaptation of the Bryson model, incorporating the Department of Health and Human Services (DHHS) as the focal organization, is presented in Figure 28. Because of the large number of organizations active in the Health and Human Services (HHS) environment and the need for clarity of presentation, the model depicted in Figure 28 presents only groups of organizations. Organizations included within each group and a brief description of their position regarding health care reform follows.

1. Medical Associations

In excess of twelve different medical associations representing numerous physicians' groups in various capacities took an active interest in the development and administration of the Medicare Fee Schedule (MFS). (Department of Health and Human Services, 1991, pp. 1-179) A brief description of these organizations follows.

- American Academy of Family Physicians (AAFP): Represents 74,000 physicians. Supports some sort of limit on physicians' fees. (Rich, 1992, p. 4)
- American Academy of Ophthalmology: An international association of more than 21,000 ophthalmologists, that is physicians who provide comprehensive eye care, including medical, surgical and optical care. (American Academy of Ophthalmology, 1995, World Wide Web Home Page)
- American Academy of Pediatrics: Supports health insurance coverage for all children and pregnant women. Wants to contain costs by requiring consumers to pay premiums, deductibles, and coinsurance and by emphasizing preventive care. (Lieberman, 1993, p. 37)

- American College of Cardiology: A nonprofit professional medical society and teaching institution with 22,500 members. Founded in 1949, the College is dedicated to fostering optimal cardiovascular care and disease prevention through professional education, promotion of research, leadership in the development of standards and guidelines in the formulation of health care policy. (American College of Cardiology, 1995, World Wide Web Home Page)
- American College of Physicians: Represents 77,000 specialists in internal medicine. Supports a national health care budget and negotiated fee schedules for doctors and hospitals. (Lieberman, 1993, p. 37)
- American College of Radiology: Represents diagnostic radiologists and radiation oncologists throughout the United States. (American College of Radiology, 1995, World Wide Web Home Page)
- American College of Surgeons (ACS): Represents 50,000 of the nation's surgeons. Membership represents the highest-paid physicians with salaries averaging \$220,500. (Jacobson, 1991, p. 1B)
- American Medical Association (AMA): Lobbies on behalf of 300,000 physicians, residents, and medical students. Historically, has opposed national health insurance. Currently wants to require employers to provide insurance for all workers, but opposes constraints on physician fees. (Lieberman, 1993, p. 37)
- American Nurses Association: Represents 200,000 registered nurses. Supports expansion of primary and preventive care delivered by a range of health care providers. (Lieberman, 1993, p. 37)
- American Society of Anesthesiologists: An educational and professional association with a membership in excess of 34,000. (American Society of Anesthesiologists, 1995, World Wide Web Home Page)
- American Society of Internal Medicine (ASIM): Represents approximately 15,000 physicians (Whitaker, 1978, p. B1) and 26,000 internists (UPI, 1993, Domestic News). Membership opposes a national cap on total health care spending and a single nationwide physician schedule. (UPI, 1993, Domestic News)
- Physicians for a National Health Program: Represents 5,000 physicians. Supports a single-payer model based on the Canadian health care system. (Lieberman, 1993, p. 37)

2. Hospital Representative Organizations

Though hospital representative organizations are not traditionally associated with Medicare Part B services, they do serve to represent physicians and other health care providers in numerous other capacities. Because of the potential for hospital representative organizations to either directly or indirectly influence key decision makers, they have been incorporated into the model. Examples and a brief description of hospital representative organizations follow.

- American Hospital Association: Represents 5,000 profit and nonprofit hospitals. Publishes a book of statistics on hospital utilization and finance. Opposes caps on national health care expenditures and supports organizing providers into community-care networks. (Lieberman, 1993, p. 37)
- Catholic Health Association: Represents 1,200 Catholic health care systems and facilities. Promotes reform proposals based on networks of providers that compete on quality and service rather than price. (Lieberman, 1993, p. 37)
- Federation of American Health Systems: Represents for-profit hospitals and health care systems. Supports free-market approaches to reform such as privatizing Medicare and Medicaid. (Lieberman, 1993, p. 37)

3. Citizen and Consumer Groups

As indicated by the discussion of citizen groups in the literature, including transcripts pertaining to the physician payment reform effort, these groups appear to have played an active role in the process. Examples of these groups and the nature of their involvement follow.

- American Association of Retired Persons: Represents 34 million Americans over age 50. (Bunis, 1993, p. 19) Advocates health care for all and improvements in Medicare and Medicaid. Offers consumer and health information, sells insurance, and operates a mail-order pharmacy for members. (Lieberman, 1993, p. 37)
- Citizen Action: A federation of 32 state citizen organizations that work on health care, energy, and environmental issues. (Lieberman, 1993, p. 37) Coalition includes groups consisting of labor and the elderly that are pushing to save money by replacing health insurance companies with a government agency to collect premiums and pay claims. (Linsalata, 1992, p. 6B) Supports a Canadian-style health care system. Makes available research reports and materials. (Lieberman, 1993, p. 37)
- Consumers Union: Publishes Consumer Reports, rates insurance policies, and lobbies for health care reform and other issues of interest to consumers. Supports a single-payer system. Makes available articles published in Consumer Reports. (Lieberman, 1993, p. 37)
- Families USA: Lobbies for affordable long-term care, health care for everyone, and income security for older Americans. Conducts studies and issues reports. Maintains a victim referral service for the press. (Lieberman, 1993, p. 37)
- Health Access: A California Coalition including unions, religious, and consumer organizations. Advocates equitable access to comprehensive health benefits, including long-term care. (Lieberman, 1993, p. 37)
- Public Citizen Health Research Group: Conducts research on various health care issues such as physicians' fees, hospital quality, occupational safety, and unnecessary surgery. Supports a single-payer system. (Lieberman, 1993, p. 37)

4. Insurance Groups and Lobbies

Examples of groups representing the insurance industry during the reform process include the following.

- Health Insurance Association of America: Major lobbying organization for 270 health insurance companies. Provides statistical information on health insurance. Supports managed care arrangements and a requirement for all employers to provide health insurance for employees. Opposes caps on insurance premiums. (Lieberman, 1993, p. 37) Also opposes mandatory health alliances but supports employer mandate. (Bunis, 1993, p. 21)
- Blue Cross Blue Shield Association: Represents 72 Blue Cross Blue Shield organizations. Supports managed competition and requirements for employers to provide health insurance for workers. (Lieberman, 1993, p. 37)

5. Managed Care Providers

Examples of five managed care provider organization representatives are given below:

- American Managed Care and Review Association: Represents Preferred Provider Organizations (PPOs), utilization review organizations, and other managed care groups. (Lieberman, 1993, p. 37)
- InterStudy: Publishes a directory of HMOs and has data on the HMO industry. (Lieberman, 1993, p. 37)
- Group Health Association of America: Represents more than 400 of the nation's 550 HMOs. (Frieden, 1992, p. 46) Conducts research and has reports, periodicals, and in-house experts available. (Lieberman, 1993, p. 37)
- Managed Health Care Association: Represents 114 large companies interested in promoting managed care for employees. Conducts research on health outcomes. (Lieberman, 1993, p. 37)
- National Committee for Quality Assurance: An independent, non-profit institution that reviews and accredits health maintenance organizations and other managed care plans. Its principal purpose is to foster development of internal systems for continuous quality improvement modeled after the Deming methods. (Wojcik, 1991, p. 1) Sends out teams to evaluate plans against specific criteria. (Lieberman, 1993, p. 37)

6. Think Tanks and Research Groups

Examples of academic and research organizations active in physician payment reform include:

- Employee Benefit Research Institute: A private nonprofit, nonpartisan research organization that conducts studies and polls on health insurance, health care utilization, cost containment, health care delivery, long-term care, and retiree health financing. (Lieberman, 1993, p. 37)
- Heritage Foundation: Public policy research institute that promotes a free-market approach to solve the health care dilemma. (Lieberman, 1993, p. 37)
- National Center for Policy Analysis: A pro-business, pro-free enterprise policy research organization that has available a number of studies and experts on health issues. (Lieberman, 1993, p. 37)
- National Health Policy Forum: Nonpartisan policy analysis and research organization affiliated with George Washington University that provides federal agencies and congressional staff with information on financing and delivery of health care services. (Lieberman, 1993, p. 37)
- Rand Corporation: Conducts studies on health issues such as quality of care and medical appropriateness. (Lieberman, 1993, p. 37)
- The Brookings Institution: Conducts research on federal health care issues and health programs such as Medicare, Medicaid, and long-term care. (Lieberman, 1993, p. 37)
- The Urban Institute: Private, nonprofit research group that investigates social and economic problems, government programs and policies. Maintains a health policy center. (Lieberman, 1993, p. 37)

7. Medical Equipment Manufacturers

An example of an organization representing medical equipment manufacturers follows.

- Health Industry Manufacturers Association: Represents makers of medical devices, diagnostic products, and health care information systems. Lobbies and conducts educational seminars. (Lieberman, 1993, p. 37) Membership comprises only 300 of the more than 2,000 medical device vendors nationwide. (Wagner, 1993, p. 12)

8. Pharmaceutical Companies

Examples of organizations representing the interests of pharmaceutical manufacturers include:

- Nonprescription Drug Manufacturers Association: Represents 75 U.S. makers of over-the-counter drugs (Colburn, 1993, p. Z9). Has materials on cost effectiveness of over-the-counter drugs. (Lieberman, 1993, p. 37)
- Pharmaceutical Manufacturers Association: Represents drug companies that develop and manufacture prescription drugs. Supports comprehensive prescription drug coverage in required benefit package and managed competition without price controls on pharmaceuticals. (Lieberman, 1993, p. 37)

9. Foundations

Examples of foundations and the manner in which they have participated in the health care reform environment follow:

- The Commonwealth Fund: A national philanthropic organization that conducts research on health, education, and aging issues. (Lieberman, 1993, p. 37)
- The Henry J. Kaiser Family Foundation: Awards grants and conducts research on

health policy and public health issues such as reproductive health and AIDS. (Lieberman, 1993, p. 37)

- The Robert Wood Johnson Foundation: Awards grants and conducts research on a variety of health issues including long-term care, cost containment, and substance abuse. (Lieberman, 1993, p. 37)

10. Unions

The AFL-CIO was selected as an example of union involvement in the physician payment reform process because the federation is composed of approximately seventy-five affiliated unions. Examples of AFL-CIO union affiliates include: a) Air Line Pilots Association, b) United Automobile, Aerospace & Agricultural Implement Workers of America International Union, c) International Brotherhood of Electrical Workers, and d) International Brotherhood of Teamsters. A brief description of the federation follows:

- AFL-CIO: Represents labor unions. Supports health care spending budgets for the nation. (Lieberman, 1993, p. 37) Opposes taxing health benefits to cover the uninsured. (Neuffer, 1993, p. 1) From January 1991 to November 1993, "the union had given \$822,210 in political action contributions to congressional candidates (Neuffer, 1993, p. 1). Supports a single payer solution to health care reform. (Frieden, 1992, p. 46)

11. Employer Groups

Business was represented in the health care reform process in a number of different ways. In addition to the direct lobbying of key decision makers by company representatives, a number of coalition groups was formed. Examples of business and business coalition groups active in physician payment reform are given below.

- Business Roundtable: Represents approximately 200 of the nation's largest companies. Has endorsed limits on both employer's tax deductibility and employees' tax exclusion for health benefits. (Wagner, 1993, p. 25)
- Council on Competitiveness: Represents the chief executive officers of 140 U.S. firms. (Elmer-Dewitt, 1994, p. 44) Studies include the effects of company health care costs on international competition. (Burke, 1990, p. 32)
- Chrysler Corporation: Company has been a leader in discussing health care costs from the point of view of multi-national corporations. (Lieberman, 1993, p. 37)
- Health Care Equity Action League: A coalition of some 630 providers, businesses, and trade associations that advocates reform based on free-market principles. (Lieberman, 1993, p. 37)
- National Association of Manufacturers: Represents 12,500 manufacturers and studies issues dealing with health care, cost containment, employee benefits, and federal programs affecting employees. (Lieberman, 1993, p. 37) Does not advocate expansion of government programs. (Pear, 1990, p. 24)
- National Committee for Quality Health Care: Trade group of 140 employers, health care providers, and managed care organizations that support managed competition and believe global budgets are inconsistent with managed competition. (Lieberman, 1993, p. 37)
- National Federation of Independent Business: Represents 600,000 small businesses, the majority of which have fewer than 50 employees. Opposes requirements for employers to provide health insurance. (Lieberman, 1993, p. 37)
- National Leadership Coalition for Health Care Reform: Formerly known as the National Leadership Commission on Health Care. Coalition includes business interests, labor unions, providers and consumer groups. Proposals include a global, federally sanctioned health care budget and uniform rate-setting for all health care payers. (Frieden, 1992, p. 77)
- National Small Business United: Represents 65,000 small businesses many of which employ fewer than 20 workers. Opposes requirements that employers provide health insurance. Supports insurance reform and managed competition. (Lieberman, 1993, p. 37)

- Washington Business Group on Health: Membership includes large corporations interested in health issues. (Lieberman, 1993, p. 37) Represents approximately 185 Fortune 500 companies. (Burke, 1990, p. 32) It believes that its efforts are best spent on congressional education. (Frieden, 1992, p. 46)

12. Government Organizations

Government organizations that had a role in the development and initial execution of physician payment reform that are external to the Department of Health and Human Services (DHHS) include:

- General Accounting Office: Legislative branch agency that reports to Congress with data, information, and unbiased analysis of how government dollars are spent. Has reports on health care and health care financing. Publishes monthly list of reports and testimony. (Lieberman, 1993, p. 37)
- Census Bureau, Poverty and Wealth Statistics Branch: Provides data on persons covered by Medicaid, Medicare, and private health plans. (Lieberman, 1993, p. 37)
- Office of Technology Assessment, Health Programs: Acts on requests from congressional committees for studies on health care technologies and the cost and quality of health care. (Lieberman, 1993, p. 37)
- Congressional Budget Office: Studies health insurance issues, including Medicare and Medicaid, and provides cost estimates for congressional proposals. (Lieberman, 1993, p. 37)
- House Energy and Commerce Committee, Subcommittee on Health and the Environment: Has jurisdiction over most health legislation, national health reform proposals, mental health, long-term care, and family planning. (Lieberman, 1993, p. 37)
- House Committee on Ways and Means, Subcommittee on Health: Has jurisdiction over legislation dealing with health programs supported by tax revenues, including Medicare. (Lieberman, 1993, p. 37)

- Senate Labor and Human Resources Committee: Has jurisdiction over health insurance legislation, mental health, medical devices, public health, and family planning. (Lieberman, 1993, p. 37)
- Senate Finance Committee: Has jurisdiction over health programs supported by tax revenues, including Medicare and Medicaid. (Lieberman, 1993, p. 37)
- Physician Payment Review Commission (PPRC): Support agency created by Congress in the mid-1980s. The Physician Payment Review Commission (PPRC) has “come to play a crucial role in Congressional oversight of Federal health programs and in the design of cost control measures for such programs” (Mann and Ornstein, 1995, p. 7). “A regular source of technical assistance for the three committees with jurisdiction over Medicare-- the Ways and Means Committee and the Energy and Commerce Committee in the House, and the Finance Committee in the Senate”. (Mann and Ornstein, 1995, p. 106)
- Democratic Party: Tends to support mandatory government-directed proposals. (DeLew, et al., 1992, p. 151) Differences exist within the party. A portion of the membership favored “proposals requiring employers to provide a minimum health insurance package or pay a tax to support public provision of coverage to their employees”(DeLew, et al., 1992, p. 151). Other positions included support for “the Canadian or State-budgeted model and the Medicare or federally budgeted model”(DeLew, et al., 1992, p. 151).
- Republican Party: Tends to support voluntary market-based proposals. (DeLew, et al., 1992, p. 151) Republican positions included that described by a bill proposing the Health Equity and Access Improvement Act of 1991. (Burke, 1992, p. 32) The plan favored “tax credits for individuals’ purchase of health insurance, tax credits for small businesses, tax credits for preventative care, and tax credits for managed care” (Burke, 1992, p. 32).
- National Governor’s Association: Endorsed using spending caps to control health care costs. (Wagner, 1993, p. 25) Endorsed limits on both employers’ tax deductibility and employees’ tax exclusion for health benefits. (Wagner, 1993, p. 25)

C. ENVIRONMENTAL PROPERTIES

The extent to which the Department of Health and Human Services (DHHS) operates in an open system is implied by Mann and Ornstein's statement that "health care reaches deeply into the economy and society, touching every individual and enterprise" (Mann and Ornstein, 1995, p. 12). This statement suggests that the actions of the Department of Health and Human Services (DHHS), as the administrator of government health care programs, have the potential to affect not only sectors of society but the population at large. Consistent with the properties of an open system, those affected by Department policies and decisions have the ability to respond through their elected officials.

The complexity of this relationship is further increased by an environmental property described by Schick (1995) as "hyperpluralism". Hyperpluralism is characterized by "the vast growth in the number of interest groups and especially in the trade associations and 'Washington Representatives' seeking to influence national policy" (Schick, 1995, p. 238). This "fracturing" of the environment into a larger number of special interests places additional demands on the Department of Health and Human Services (DHHS) as it is confronted with the increasing number of environmental linkages that must be managed.

1. Hyperpluralism in the Medical Community

In a hyperpluralistic environment, as the number of associations multiplies, "the capacity of a parent group to represent specialized interests, or to speak for the entire sector diminishes" (Schick, 1995, p. 238). An example of hyperpluralism in health care reform includes the American College of Physicians' unveiling of 16 criteria "that any overhaul of the

system should meet, while at the same time refusing to sign on with the American Society of Internal Medicine (ASIM), which endorsed the American Medical Association's (AMA) Health Access America plan" (Conroy, 1991, p. 38). In another instance, the Physicians for a National Health Plan referred to "American Medical Association talk about health care reform as simply that: rhetoric" (Abramowitz, 1991, p. Z10).

Yet another example of this effect is illustrated in Representative Pete Stark's August 1991 interview with Medical World News. Then chairman of the House Ways and Means Health Subcommittee, Stark described a process in which the committee dealt with a variety of medical interest groups rather than a single representative of the medical community. Stark described

. . .making deals with all those groups-- surgeons, ophthalmologists, radiologists, anesthesiologists, nurses-- while the AMA has sort of been sitting off on the sidelines saying, "We don't like what they're doing. (Pollner, 1991, p. 26)

2. Hyperpluralism in Government

A phenomenon similar in effect to that suggested by hyperpluralism may be observed within the Legislative branch. In Congress, jurisdiction over health care issues "is spread over numerous committees and subcommittees in the House and Senate" (Mann and Ornstein, 1995, pp. 1-2). Mann and Ornstein to suggest that legislative jurisdiction is more complex than the relationships involving the four committees identified in the environmental model as having jurisdiction over health care issues. Although the House Energy and Commerce

Committee, House Committee on Ways and Means, Senate Labor and Human Resources Committee and Senate Finance Committee “hold the lion’s share of health jurisdiction . . . the scope and underlying policy area [health care] virtually guarantees that almost every committee will have a legitimate claim to some piece of the action” (Mann and Ornstein, 1995, p. 3). Consequently, from the perspective of Health and Human Services (HHS), the linkage between health care interest groups and Congress is not a singular channel but a network of multiple conduits leading to members of Congress and congressional committees.

3. Hyperpluralism in Other Interest Groups

The Department of Health and Human Services (DHHS) must also consider its linkages with citizen and consumer groups. Fracturing within these groups is observable in a manner similar to that present in government and medical groups. This phenomenon is illustrated by considering the elderly. Although the elderly are largely the most immediately affected group with regard to physician payment reform, literature exists that suggests that they may also have difficulty maintaining a united position. An explanation of their predicament is suggested by Pauly in which he indicates that the “split of the elderly into ‘haves’ and ‘have nots’ will make it difficult to maintain a united social insurance facade” (Pauly, 1988, p. 65).

Examples of similar behaviors for the remaining organizations in the Health and Human Services (HHS) environment are presented in government transcripts, professional journals and the popular literature. Additional examples relevant to the development and

implementation of the Medicare Fee Schedule (MFS) will be introduced as schedule components are discussed.

D. ORGANIZATIONAL ACTIVITY IN PAYMENT REFORM

The Department of Health and Human Services (DHHS) received its first instructions from Congress to begin the development of a physician fee schedule based on a relative value scale in the form of mandates contained in the Omnibus Budget Reconciliation Acts (OBRA) of 1985, 1986 and 1987. (Department of Health and Human Services, 1991, p. 15) For assistance in this undertaking, the Department employed a "number of experts inside and outside of government"(Department of Health and Human Services, 1991, p. 15). The Harvard University School of Public Health was contracted to do much of the Relative Value Scale (RVS) development. The Urban Institute (UI) and the Center for Health Economics Research (CHER) have been described by Health and Human Services (HHS) as being "instrumental in the development of the Geographical Practice Cost Indexes (GPCIs)" (Department of Health and Human Services, 1991, p. 15). In addition to these private sector organizations, Health and Human Services (HHS) has described the contributions of the Physician Payment Review Commission (PPRC) as "invaluable . . . and extremely useful at every stage of the fee schedule development" (Department of Health and Human Services, 1991, p. 30).

Formal congressional controls were maintained during the early development of the fee schedules by requirements set forth in the Omnibus Budget Reconciliation Acts (OBRA) of 1985, 1986 and 1987 that the Department of Health and Human Services (DHHS) submit

three reports no later than October of 1989 that summarized “the results of extensive research and analysis relating to the possible implementation of a Medicare physician fee schedule” (Department of Health and Human Services, 1991, p. 15). These reports were entitled the “Volume and Intensity of Physician Services”, “Relative Value Scales for Physician Services”, and “Implementation of a National Fee Schedule”(Department of Health and Human Services, 1991, p. 15).

Approximately two months after receiving the October 1989 Health and Human Services (HHS) report, Congress provided specific instructions to the Department of Health and Human Services (DHHS) regarding the procedures and methods that would be used to implement a relative value based physician fee schedule by January 1, 1992. Although the Omnibus Budget Reconciliation Act (OBRA) of 1989 provided some specific guidance, it has been described by Health and Human Services (HHS) as having “left a number of key payment policy and technical issues to the Secretary of Health and Human Services for resolution” (Department of Health and Human Services, 1991, p. 15).

One of the specific congressional requirements provided to Health and Human Services (HHS) in the Omnibus Budget Reconciliation Act (OBRA) of 1989 was that a model of the fee schedule be made available to the public by September 1, 1990 “in order to provide an early opportunity for public review of the fee schedule methodology” (Department of Health and Human Services, 1991, p.15). The model was published by Health and Human Services (HHS) on September 4, 1990 and included: a) a description of statutory requirements, b) identification of technical and policy issues for which the Secretary of the

Department of Health and Human Services (DHHS) had discretion, c) a summary of actions that had already been taken regarding fee schedule development, and d) a summary of planned actions for resolving issues that required resolution prior to program implementation. It should be noted that in their discussion of program options, Health and Human Services (HHS) identified “preferred options . . . in some cases” while “in other cases options were discussed without identification of a preferred approach” (Department of Health and Human Services, 1991, p. 16).

On June 5, 1991, the Department of Health and Human Services (DHHS) published in the Federal Register their proposed rule for establishing a physician fee schedule by January 1, 1992. Upon its release, Louis W. Sullivan, M.D., then Secretary of the Department of Health and Human Services (DHHS), described the payment system as intended to “help address longstanding imbalances between Medicare payments to urban and rural physicians and between primary care physicians and certain specialties, such as surgeons” (Fisher, 1991, p. 3) However, not all organizations in the Health and Human Services (HHS) environment shared Dr. Sullivan’s prognosis for the proposed rule.

On July 31, 1991 the Physician Payment Review Commission (PPRC), “sharply criticized details of the nationwide fee schedule that the Bush Administration planned to put into effect” in January 1992 (Pear, 1991, p. 17). In their statement, the Commission described the proposed implementation as posing “serious risks to beneficiaries’ access to care” and threatening “the integrity of the physician payment reform approved by Congress in 1989” (Pear, 1991, p. 17). The American Academy of Family Physicians (AAFP),

characterized by Pollner as “the physician specialty most favored by the new Medicare fees schedule,” described the Department of Health and Human Services (DHHS) action as a “betrayal” (Pollner, 1991, p. 60).

During the Physician Payment Review Commission (PPRC) hearings that followed release of the proposed plan, the American Medical Association (AMA), American Society of Internal Medicine (ASIM), the American College of Surgeons (ACS), the American Academy of Family Physicians (AAFP) and other medical groups joined in warning the Commission that “physicians’ confidence in and cooperation with payment reform and the Medicare program are in serious jeopardy” (DER No. 113, 1991, p. A-4). The American Medical Association (AMA) added that, “contrary to Congress’ intent and its commitment to physicians,” the Health and Human Services (HHS) proposed rule transformed “payment reform into a budget cutting tool” (DER No. 113, 1991, p. A4).

Upon conclusion of the Physician Payment Review Commission (PPRC) hearings a report was made to Congress summarizing the findings of the Commission pertaining to fee schedule implementation. The report included language indicating that the Commission “found significant problems that, if not corrected, might jeopardize the success of payment reform . . . perhaps the most critical” being the conversion factor (Lee, et al., 1991, p. 1562).

Also cited by the Commission were “significant distortions” remaining in the Relative Value Scale (RVS) (Lee, et al., 1991, p. 1562). In the end “physician groups all agreed with the American Medical Association’s (AMA) conclusion that the number 1 priority in its battle plan should be to restore the conversion factor to its intended level,” which was the level

consistent with medical group interpretations of the congressional requirement for budget neutrality (McIlrath, 1991, p. 1).

Reactions on the part of the Department of Health and Human Services (DHHS) organizational environment to the perceived intent of the proposed rule mark a change in the degree of hyperpluralism in this environment. As observed by Physician Payment Review Commission (PPRC) member J. Eisenberg, the Health and Human Services' (HHS) proposed implementation of physician payment reform had the effect of achieving "lateral consensus here among providers and beneficiaries for the first time in the five years we've been addressing this (payment reform) . . . it's really quite heartwarming" (Pollner, 1991, p. 60).

1. The Conversion Factor (CF)

The proposed rule for a physician fee schedule incorporated a Conversion Factor value of \$26.87 to be used in the implementation of the Medicare Fee Schedule (MFS). The Health Care Financing Administration (HCFA) acknowledged "that amount had been reduced by 16 percent in order to maintain budget neutrality" (Medicine & Health, 1992, [no page no. provided]) The Health Care Financing Administration (HCFA) reduction was based upon an assumption that in order to maintain budget neutrality under the new fee schedule they would have to allow for changes in provider and beneficiary behavior as well as the effects of the transition schedule described in Chapter II. The physician behavior which the Administration was anticipating was an increase in the volume of services provided in order to compensate for lost income. Of the proposed reduction, 6 percent was attributed to the effects of the

transition schedule while 10 percent was allowed for the behavioral offset. (Medicine and Health, 1992, [no page no. provided])

One of the objections to the assumption's 16 percent discount in the Conversion Factor (CF) was the implication that physicians would respond to the policy by increasing volume to regain lost income. (Medicine & Health, 1992, [no page no. provided]) Physicians appeared to object not only to the level of the offset but also to its implication that "they practiced medicine for monetary purposes rather than for the patient's best interest" (Medicine & Health, 1992, page number not provided).

Another objection to the Conversion Factor was the acknowledgment by the Administration that the fee schedule "would save the Government a total of at least \$6.9 billion. . .from 1992 to 1996" (Pear, 1991, p. 17). This acknowledgment led to disputes between the Health Care Financing Administration (HCFA) and interest groups over the propriety of the agency's interpretations of the budget neutrality requirements put forth in the Omnibus Budget Reconciliation Act (OBRA) of 1989. The Physician Payment Review Commission's (PPRC) charged that "it is not credible that Congress intended substantial budget savings" in its requirement for budget neutrality. (Pear, 1991, p. 17)

Differences between the Health Care Financing Administration (HCFA) and interest groups over the appropriate Conversion Factor (CF) value were resolved by compromise. In the publication of the final rule governing fee schedule implementation, "the conversion factor was set at \$30.42, 13.2 percent higher than under the proposed rule" (Medicine and Health, 1992, [no page no. provided]). In addition to the 13.2 percent concession, inflation

was applied to the \$30.42 figure, raising it to \$31.00 in 1992 (Medicine and Health, 1992, [no page no. provided]).

A number of interest groups indicated satisfaction with the compromise. The American Medical Association's (AMA) executive vice president, James S. Todd, suggested that "physicians generally are pleased with HCFA's accommodations" (Medicine and Health, 1992, [no page no. provided]). The American Medical Association (AMA) responded to the Administration's compromise by electing not to continue to "push to get the behavioral offset legislatively changed" (Medicine and Health, 1992, [no page no. provided]). In accepting the behavioral adjustment, the American Medical Association's (AMA) Todd acknowledged that volume of services provided was going to increase, but he attributed the increase to "reasons that are not related to physician behavior, but . . . tied to factors such as the emergence of new technology and the aging of the U.S. population" (Medicine and Health, 1992, [no page no. provided]).

2. Relative Value Scale

The American Medical Association (AMA) also took issue with Health Care Financing Administration (HCFA) testimony before Congress "that the Relative Value System (RVS) had been made as accurate as possible" (Lee, et al, 1991, p. 1562). Differences in the intentions communicated in the Notice of Proposed Rule Making (NPRM) in 1991 regarding the redistribution of payments and those expected by physicians appear to have been the source of much of the disappointment in the medical profession.

Specifically, physicians had anticipated that the Relative Value Scale (RVS) would "increase payments for primary care by about 30 percent and . . . reduce payments for surgery and other procedures by about 16 percent overall" (McIlrath, 1991, p. 1). Instead, the information published in the June 5, 1991 proposed rule indicated that the Health Care Financing Administration (HCFA) predicted that:

. . . only one medical specialty -- family and general physicians -- will see payments rise. All others, including the internists who first pushed for RBRVS [Resource Based Relative Value Scale], will see payments decline. Surgeons, along with radiologists, anesthesiologists and pathologists, will see payments for their services plunge by 25% to 35% (McIlrath, 1991, p. 1).

In addition to medical interests such as the American Society of Anesthesiologists (ASA) and the American Academy of Ophthalmology (AAO) voicing objections to the magnitude of the proposed reductions for their communities, the American Medical Association (AMA) and other physician's groups argued that the reduction in payments to internists as a result of the proposed scale "undermined one of the key objectives of payment reform" (McIlrath, 1991, p. 1). These Associations argued that by not furnishing incentives for increasing the number of participating internists there would be a decrease in the number of primary care providers. Regarding the effect of the proposed Relative Value Scale (RVS) on providers, physicians indicated that

. . . internists now face lower payments even though they primarily provide evaluation and management services and "see more Medicare patients than any other" specialty. (McIlrath, 1991, p. 1)

The American Medical Association (AMA) and other physician groups also indicated that the Relative Value Scale (RVS) as published in the proposed rule (Department of Health and Human Services, 1991, p. 1- 179) would reduce payments "in all states-- even those with many underserved rural areas" (McIlrath, 1991, p. 1). The American Academy of Family Physicians (AAFP) acknowledged "some payment gains" but indicated that the magnitude of the increases were "unlikely to draw more medical students to family practice and rural areas" (McIlrath, 1991, p. 1).

Another objection raised by special interest groups to the proposed Relative Value Scale (RVS) included in the final rule concerned the data used in determining it. Speaking on behalf of the American Society of Internal Medicine (ASIM), Trustee J.L. Lichtenfeld, MD "urged the Physician Payment Review Commission . . to recommend that Health and Human Services (HHS) replace all existing practice cost relative value units with new ones based on the resource costs of providing each service, rather than historical charges" (Culhane, 1992, p. 9).

Confidence in the proposed Relative Value Scale (RVS) was also affected by the behavior of the Health Care Financing Administration (HCFA) prior to its implementation. Specifically, the Health Care Financing Administration (HCFA) suggested in congressional testimony that the proposed scale was not ready to be implemented and that "they preferred a 1993 RBRVS [Resource Based Relative Value Scale] arrival date" (McIlrath, 1991, p. 1). Their request for an extension was not granted. Having been ignored by Congress, the Administration espoused the position that they would "try to be as responsive as we can to

problems that arise . . . but we hope that physicians will give us a lot of help and understanding" (McIlrath, 1991, p. 1).

As a result of special interest group objections and the Administration's efforts to revise to the Relative Value Scale (RVS) within two months of program implementation, the Relative Value Scale (RVS) "published in the final rule was considered interim" and subject to change in 1993 (McIlrath, 1991, p. 1). Resolution of differences between the American Medical Association (AMA) and other physician groups over the Relative Value Scale (RVS) was still pending in 1992. A notable response of the Health Care Financing Administration (HCFA) to physician concerns has been to decrease the review and update periodicity for the Relative Value Scale (RVS) from the legislative requirement of at least once every five years to every year.

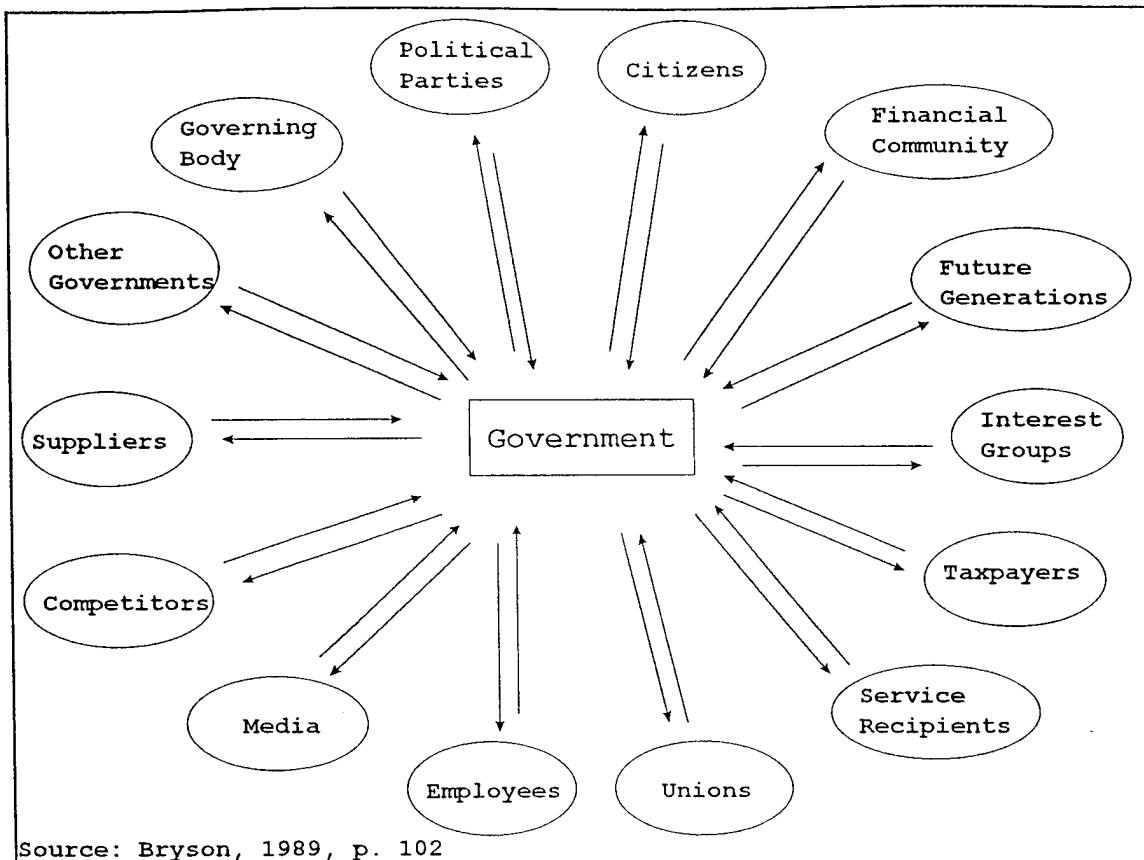
3. Geographic Practice Cost Indexes

As discussed in Chapter II, the Geographic Practice Cost Indexes were an important part of the proposed rule issued by the Health Care Financing Administration (HCFA). Although the Indexes were intended to correct for imbalances between rural and urban physician payment rates, the literature indicates that the values presented in the proposed rule were not favorably received by physician groups such as the American Medical Association (AMA).

The specific goal of the American Medical Association (AMA) regarding the proposed Geographic Practice Cost Indexes (GPCIs) was to "correct flawed proxy data used to calculate" index values (DER No. 12, 1992, p. S-39). As indicated in the December 9,

1991 American Medical News, "virtually everyone complained that much of the data used to construct the indexes was outdated" (McIlrath, 1991, p. 1). In response, the Health Care Financing Administration (HCFA) "promised to redo the indexes when data from the 1993 census and a survey of professional liability costs are available" (McIlrath, 1991, p. 1)

This chapter has considered the organizational environment for the Department of Health and Human Services (DHHS) during the development and implementation of physician payment reform from a macro perspective. Chapter V models and employs the perspectives offered by institutional and resource dependency theory in order to develop a greater understanding of the events that transpired during reform implementation.



Source: Bryson, 1989, p. 102

Figure 27. Bryson's Stakeholder Map for a Government.

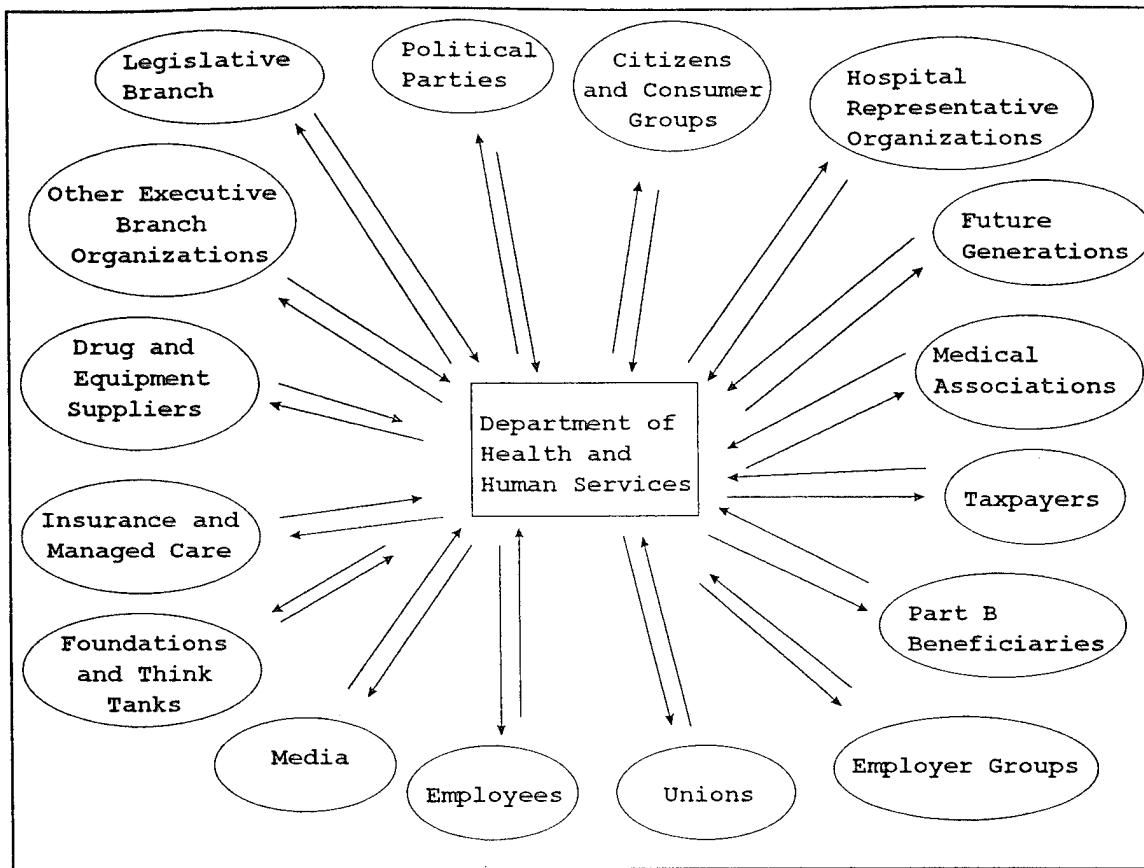


Figure 28. The Organizational Environment of the Department of Health and Human Services (DHHS).

V. PERSPECTIVES ON REFORM

A. INTRODUCTION

This chapter considers the development and implementation of physician payment reform described in Chapters I, II, and IV from an institutional and resource dependency perspective. Specifically, using the Department of Health and Human Services (DHHS) as the focal organization, the theories described in Chapter III, are used to inform the discussion of the events that transpired during the implementation of the Medicare Fee Schedule (MFS).

B. APPROXIMATING ACTIVITY IN THE ENVIRONMENT

In this portion of the analysis the model of the Department of Health and Human Services (DHHS) organizational environment was defined as the activity of the special interest groups involved in physician payment reform. Specifically, activity was approximated by the frequency of references to an organization in a sample of the health care related literature. The health care related literature comprising the sample consisted of a total of 1750 pages from 147 articles obtained from the LEXIS[®] /NEXIS[®] data base. Examples of the sources from which the articles were drawn include government publications (e.g. Health Care Financing Review), medical publications (e.g. The Journal of the American Medical Association, New England Journal of Medicine, Modern Health Care, Medicine and Health), business publications (Business & Health, Business Insurance, Bureau of National Affairs Pension & Benefits Reporter) and the popular press (e.g. Wall Street Journal, New York Times, Los Angles Times, The Boston Globe, etc.). Articles were restricted to the period

1984-1994 and to subjects addressing health care reform, Medicare Part B, physician payment reform, and the Medicare Fee Schedule (MFS).

The sample articles were examined for references to the 66 organizations belonging to the interest groups modeled in Figure 28. Quotations attributed to an organization in the articles or references to positions held by an organization were counted and recorded in the "frequency" column in the Appendix. The activity level for an interest group was then calculated by dividing the organization's frequency of occurrence by the total frequency for all organizations and recorded in the "activity level" column of the Appendix.

With three exceptions, to the 66 organizations screened in the sample, only those with an activity level greater than 5 percent were selected for inclusion in the analysis. The three exceptions include the Senate Finance Committee (1.64 percent), the Senate Labor and Human Resources Committee (0.48 percent), and the House Energy and Commerce Committee (0.34 percent). These organizations were included to provide a relative indication of the activity of key decision makers in the House Committee on Ways and Means and those on the other three major health care committees within the Legislative branch.

A model of the Department of Health and Human Services (DHHS) organizational environment is presented in Figure 29. In addition to the Department of Health and Human Services' (DHHS) environmental linkages, Figure 29 also identifies pathways described in the health care related literature that were used by special interest groups as they sought to influence the Health Care Financing Administration's (HCFA) implementation of the requirements of the Omnibus Budget Reconciliation Acts (OBRA) of 1989 and 1990.

C. INSTITUTIONAL PERSPECTIVE

In this section the manner in which the Department of Health and Human Services (DHHS) implemented the Medicare Fee Schedule (MFS) is considered from an institutional perspective. This portion of the analysis places emphasis on: a) the organizational structure adopted by the Department of Health and Human Services (DHHS) to facilitate implementation of the reform requirements, b) the manner in which resource generation was addressed in Department of Health and Human Services (DHHS) actions, and c) indications and measures of organizational performance for the Department of Health and Human Services (DHHS).

1. Organizational Structure

Since the inception of the Medicare Program one of the more prominent changes in the Department of Health and Human Services' (DHHS) organizational structure was the formation of the Health Care Financing Administration (HCFA). Institutional theory suggests that the creation of the Health Care Financing Administration (HCFA) allowed the Department of Health and Human Services (DHHS) to integrate with the environment and create the image of meeting the increasing demands being made by the complex environment that was described in Chapter I.

Institutional theory also suggests that the Department of Health and Human Services (DHHS) would use the organizational structure to buffer the technical core of the organization. As the primary point of contact for issues related to physician payment reform, the Health Care Financing Administration (HCFA) provided a means to buffer core activities of the Department of Health and Human Services (DHHS) from the uncertainties of the

implementation of the Medicare Fee Schedule (MFS). The effectiveness of this buffer is evident from the quantity of direct exchanges between the Health Care Financing Administration (HCFA) and Congress, the Physician Payment Review Commission (PPRC) and special interest groups that are described in the health care related literature.

Similarly, by employing the services of organizations such as the Urban Institute (UI), the Center for Health Economics Research (CHER), and the Harvard School of Public Health, the Health Care Financing Administration (HCFA) was also able to provide buffering between the Department and its environment. Had the Administration elected to develop the proposed rule through the exclusive use of internal resources, proof of the validity of the methodology employed would have rested entirely with the Health Care Financing Administration (HCFA). Instead, the Health Care Financing Administration (HCFA) decoupled itself from a portion of the development of the Notice of Proposed Rule Making (NPRM) in effect, shielding itself and the Department of Health and Human Services (DHHS) by purchasing expertise and legitimacy from the organizations with which it contracted.

2. Resource Generation

Institutional theory suggests that the Department of Health and Human Services (DHHS) would construct the Notice of Proposed Rule Making (NPRM) so that the proposed rule conformed with the expectations of the organizations in the environment. By conforming with environmental expectations, the Department of Health and Human Services (DHHS) would be acting in a manner that would allow the proposed rule to be perceived as legitimate by both Congress and other environmental organizations. Furthermore, by conforming with

the norms and expectations of reform, the Department of Health and Human Services (DHHS) would be acting to protect the scarce resources needed for survival. Specifically, conformance with norms and expectations would mitigate the risk of disturbing the flow of funding to the Department of Health and Human Services (DHHS) from the Congress.

The initial behavior of the Department of Health and Human Services (DHHS) during the implementation of reform however was not consistent with that suggested by institutional theory. The health care related literature indicates that prior to the publishing of the Notice of Proposed Rule Making (NPRM) shared beliefs regarding the intent of physician payment reform existed among the organizations in the environment. Although not a comprehensive list, the previous chapters and the health care related literature indicate the American Medical Association (AMA), Physician Payment Review Commission (PPRC), Congress and the Health Care Financing Administration (HCFA) agreed that:

- The Medicare Fee Schedule (MFS) would “include an increase in payment rates for visits relative to rates for technical procedures, thereby favoring physicians in medical specialties over those in surgical and other specialties”(Congressional Budget Office, 1990, p. xii).
- The Medicare Fee Schedule (MFS) would “include an increase in payment rates in rural areas relative to rates in urban areas” (Congressional Budget office, 1990, p. xii).
- Reform would be implemented in a manner that was budget neutral. (Department of Health and Human Services, 1991, pp. 1-171).
- A goal of physician payment reform was to “protect Medicare enrollees’ access to health care services” (Epstein, et al., 1993, p. 193).

Contrary to the behavior suggested by institutional theory, the Department of Health and Human Services (DHHS) developed a proposed rule that was perceived by the environment as communicating an intent to implement a policy that was inconsistent with the aforementioned environmental norms and expectations. These pre-rule norms and expectations are used in this analysis to illustrate how the Health Care Financing Administration (HCFA) lost legitimacy with its environment as a result of the proposed rule.

As discussed in Chapter IV, the proposed rule was not perceived by the environment as correcting inequities in payment among primary care and technical procedures. Instead, the proposed rule indicated that only family and general physicians would experience increases. Consequently, a degree of legitimacy was lost with internists and other primary care providers who believed congressional promises and the statements by the Secretary of the Department of Health and Human Services (DHHS) that payment reform would correct longstanding imbalances between primary care providers and specialists.

Furthermore, as indicated in Chapter IV, the prospective increase in general practitioner and family physician rates was viewed by the medical community as not providing an adequate incentive to attract new medical students to the primary care sector, another objective of reform. Also, as discussed in the previous chapter, in addition to the unanticipated rate reductions encountered by internists and many other primary care providers, specialists who had anticipated a decline in rates saw the magnitude of the proposed decline increase in some cases by as much as 100 percent. By departing from the expectations of both those who stood to lose as well as those who stood to gain from reform,

the Department of Health and Human Services (DHHS) created an outcome with no clear winners. As a result, the Department of Health and Human Services (DHHS) lost a measure of legitimacy and the degree of hyperpluralism in the environment decreased.

Another objective of the Medicare Fee Schedule (MFS) that the organizations in the environment perceived as being violated by the Notice of Proposed Rule Making (NPRM) was the failure of the proposed Geographic Adjustment Factors (GAFs) to raise payment rates in rural areas relative to those in urban areas. In Chapter II it was explained that the Geographic Adjustment Factors (GAFs) were intended in part to correct imbalances between rural and urban payment rates and thus encourage the migration of practitioners to the underserved rural areas. By not raising rural area payment rates, the proposed rule failed to provide the incentive required to encourage physicians to establish practices in rural, underserved regions. To the contrary, as discussed in the previous chapter, even physician payment rates in underserved rural areas were perceived by physician groups as declining under the proposed rule.

With regard to the deviations from the norms and expectations of physician payment reform as discussed in Chapter IV, one of the more prominent concerns for physician groups was the Health Care Financing Administration's (HCFA) interpretation of the requirements for budget neutrality. Two of the objections raised by the organizations in the environment addressed the underlying assumptions made by the Health Care Financing Administration (HCFA) regarding the need to apply offsets to the Conversion Factor (CF). As discussed in the previous chapter, the Conversion Factor (CF) adjustments that the Health Care Financing

Administration (HCFA) maintained were necessary to achieve budget neutrality were the behavioral and transitional offsets.

In addition to violating payment reform norms and objectives regarding budget neutrality, the Health Care Financing Administration's (HCFA) treatment of the behavioral offset was also viewed by portions of the organizational environment as challenging the belief that physicians put patient care before monetary reward. By proposing a policy that was perceived by the environment as questioning the legitimacy of the medical profession, the Health Care Financing Administration (HCFA) provided organizations with a symbol used by leaders in the environment to generate unification in opposition to the proposed rule.

Physician groups and the Physician Payment Review Commission (PPRC) also questioned the legitimacy of the behavioral offset by characterizing its effect as transforming the Medicare Fee Schedule (MFS) into a budget cutting tool. This characterization placed the behavioral offset in a context that was contrary to the expectations of organizations in the environment of a budget neutral fee schedule implementation. Again the behavior of the Health Care Financing Administration (HCFA) was inconsistent with the move toward conformity with the environment as suggested by institutional theory. This nonconformity is demonstrated in the maintenance of the Health Care Financing Administration's (HCFA) interpretation of the need for the behavioral offsets despite the acknowledgment that the behavioral offset would result in a savings of approximately \$6.9 billion over the fee schedule transition and the Physician Payment Review Commission (PPRC) announcement that the projected savings were inconsistent with congressional intent.

Simultaneously, the Health Care Financing Administration's (HCFA) suggestion that budget neutrality did not apply to the entire transition period but only to the first year led to disputes with the organizational environment over the transitional offset. Objections to the transitional offset were similar to those raised by organizations in the environment over the behavioral offset. An illustration of the manner in which the legitimacy of the offset was questioned includes the American Medical Association (AMA) obtaining an independent legal interpretation of the requirements of the reform statute that contradicted the interpretation maintained by the Health Care Financing Administration (HCFA).

Similarly, the legitimacy of both the transitional and behavioral offsets was also challenged in Physician Payment Review Commission (PPRC) hearings that resulted in the Commission's rejection of the Health Care Financing Administration (HCFA) interpretations upon which the offsets were based. Despite the resistance of the organizational environment, the Health Care Financing Administration (HCFA) remained committed to the need for the offsets.

The final illustration of the perception that the proposed rule deviated from the congressional intent for payment reform is found in the speculation of organizations in the environment regarding the impact of the rule on access to health care services. Unlike the previous three examples, the perceived threat to access is not readily observable by examining objections to single components of the proposed rule. Instead, the health care related literature suggests that organizations in the environment viewed the Notice of Proposed Rule

Making (NPRM) from a macro perspective when indicating concern for a reduction in access for Medicare beneficiaries.

As discussed in Chapter IV both the Physician Payment Review Commission (PPRC) and the American Medical Association (AMA) expressed concerned for the impact the Notice of Proposed Rule Making (NPRM) incentives would have on access. Evidence of the loss of legitimacy and the degree to which the proposed rule departed from environmental expectations is evident in the characterization of the Notice of Proposed Rule Making (NPRM) by physician groups as a “betrayal”. The health care related literature describes leaders of physician organizations as responding to the proposed rule by suggesting that, as a result of the incentives provided by the proposed implementation, fewer physicians would be willing to see Part B beneficiaries in the future.

In addition to the legitimacy lost with special interest groups, as described above and in the previous chapter, the Physician Payment Review Commission (PPRC) also considered the proposed rule as placing access to care and the intent of reform at risk. All of the organizations presented in Figure 29, formally indicated disagreement with the Health Care Financing Administration’s (HCFA) interpretation of the requirements of reform and expressed concern for the effect that the proposed rule was likely to have on beneficiary access to care.

The health care related literature indicates that the Health Care Financing Administration (HCFA) did not demonstrate a willingness to conform with environmental expectations until the special interest groups and the Physician Payment Review Commission

(PPRC) succeeded in convincing members of Congress that the proposed rule was inconsistent with the intent of reform. Up until this point, the Health Care Financing Administration's (HCFA) argument for not compromising had been based on the Health Care Financing Administration's (HCFA) belief that the proposed rule represented the best interpretation of the requirements of reform. Convinced that the Notice of Proposed Rule Making (NPRM) most closely approximated the congressional mandate, the Health Care Financing Administration (HCFA) appears to have been willing to tolerate the loss of legitimacy with the environment.

However, a prominent development that contributed to the Health Care Financing Administration's (HCFA) move toward conformity was proposed legislation that threatened congressional direction that contradicted the Health Care Financing Administration's (HCFA) interpretation of the requirements of reform. For example bills were introduced in the House of Representatives and the Senate that proposed the reduction or elimination of the behavioral and transitional offsets.

Institutional theory suggests that the one explanation for the change in the Health Care Financing Administration's (HCFA) position was the loss the proposed rule's legitimacy with the Congress. The Health Care Financing Administration (HCFA) relied upon Congress for funding, the scarce resource that it needed to survive. By continuing to support an interpretation of payment reform that was viewed as illegitimate by those who both drafted it and controlled Health Care Financing Administration (HCFA) funding, the Health Care Financing Administration (HCFA) had placed the organization's survival at risk.

On August 27, 1991, the Health Care Financing Administration (HCFA) announced that it planned to abandon the transitional offset proposal, acknowledging that "it was a mistake all in all" (BNA, 1991, p. 1). The health care related literature indicates that the congressional interpretation of the abandonment of the transitional offset was viewed as the Health Care Financing Administration (HCFA) "sending a message to Congress that legislative action [was] not necessary" (BNA, 1991, p. 1). This action symbolized for Congress the intention of the Health Care Financing Administration (HCFA) to comply with congressional expectations for fee schedule implementation.

Conformity with environmental expectations regarding the behavioral offset was not as complete as in the case of the transitional offset. Although the threatened legislative direction to reduce or eliminate the behavioral offset was never successfully passed, in November 1991 the Health Care Financing Administration (HCFA) redesignated the offset as a "baseline adjustment" and reduced its value to 6.5 percent.

From an institutional perspective renaming and reducing the behavioral offset was a significant action. By redesignating the reduction as a baseline adjustment, the Health Care Financing Administration (HCFA) was able to reduce the Conversion Factor (CF) without having to continue to confront the belief that physicians put the patient before profits. Furthermore, presenting the behavioral adjustment in this form afforded the American Medical Association (AMA) the opportunity to compromise and accept a lesser reduction by acknowledging a probable increase in patient and treatment volume due to "technology and an aging population" instead of physician behavior (Medicine and Health, 1992). Through

compromise over Conversion Factor (CF) related interpretations, the Health Care Financing Activity (HCFA) was able to diffuse many of the concerns regarding the proposed rule and its impact on budget neutrality.

Other concerns of the environment that were diffused through symbolic acts that demonstrated a willingness to compromise include a promise by the Health Care Financing Administration (HCFA) to continue to work to refine the proposed Relative Value Scale (RVS). Specifically, the Health Care Financing Administration (HCFA): a) promised to increase the frequency of review and revision of the scale from the legislatively mandated period of once every five years to once every year, b) declared the Relative Value Scale (RVS) published in the final rule as interim and subject to change in 1993, and c) extended the commentary period on the Relative Value Scale (RVS) until March 1992. (McIlrath, 1991, p. 1) Through this commitment, the Health Care Financing Administration (HCFA) demonstrated an intention to address one of the pre-rule expectations that the originally proposed Relative Value Scale (RVS) was perceived as violating, the increase in payment rates for primary care visits relative to those for technical procedures.

Resolution of concerns by medical special interest groups for the effect that the proposed rule was expected to have on the Geographic Adjustment Factors (GAFs) was handled by the Health Care Financing Administration (HCFA) in a similar fashion. As discussed in Chapter IV and in the health care related literature, reliance on "outdated" and proxy data used in the formulation of the Geographic Adjustment Factors (GAFs) was one of the more prominent concerns over adjustment factor legitimacy. Although the Geographic

Adjustment Factors (GAFs) were not adjusted in the final rule, the Health Care Financing Administration (HCFA) promised to "redo the indexes when data from the 1992 census and a survey of professional liability costs [were] available" (McIlrath, 1991, p. 1).

3. Organizational Performance

As described in Chapter IV, organizations of physicians and the American Medical Association (AMA) indicated satisfaction with the Health Care Financing Administration's (HCFA) compromise. Through conformity with environmental norms and expectations the Health Care Financing Administration (HCFA) was able to publish a final rule in November 1991 that was received as legitimate by the majority of organizations in the environment.

Although medical special interest groups such as the American Medical Association (AMA) indicated that payment reform as implemented on January 1992 did not represent an end state for reform and that many details still needed to be revised, organizations of physicians indicated general acceptance of the final rule. Evidence of the success of the Health Care Financing Administration (HCFA) regaining legitimacy for payment reform and implementing it on schedule may be found in the American Medical Association's (AMA) statement of general satisfaction with the Health Care Financing Administration's (HCFA) accommodations described in the previous chapter.

D. RESOURCE DEPENDENCY PERSPECTIVE

In this section resource dependency theory is used to examine the manner in which the Department of Health and Human services implemented the Medicare Fee Schedule (MFS). As with the institutional portion of the analysis, this examination places emphasis on:

a) the organizational structure adopted to facilitate implementation of the reform requirements, b) the manner in which resource generation requirements were addressed in Department of Health and Human Services (DHHS) actions, and c) indications and measures of organizational performance.

1. Organizational Structure

Resource dependency theory argues that the structures and activities of a focal organization are a function of its adaptive response to environmental changes as it seeks to survive. This context provides insight into the creation of the Health Care Financing Administration (HCFA) by the Department of Health and Human Services (DHHS). Specifically, one argument for the creation of the Health Care Financing Administration (HCFA) was the awareness of the Department of Health and Human Services (DHHS) of the growing complexity and increasing costs associated with the provision of Medicare benefits. By creating the Health Care Financing Administration (HCFA), the Department of Health and Human Services (DHHS) was adapting in a manner that would increase its potential for survival by dedicating resources to a segment of the environment that, as discussed in Chapter I, demonstrated the potential to remain dynamic for the foreseeable future.

Furthermore, by structuring itself in an effective manner through the creation of the Health Care Financing Administration (HCFA), the Department of Health and Human Services (DHHS) was increasing its ability to create the acceptable outcomes and actions required for survival. Specifically, the Department of Health and Human Services' dependence on congressional resources required that it remain responsive to the needs of

Congress. Resource dependency suggests that by creating the Health Care Financing Administration (HCFA), the Department of Health and Human Services (DHHS) was structuring itself in a manner that would allow it to remain responsive to its clients in Congress as the complexity of health care reform increased.

2. Resource Generation

Using a resource dependency perspective one would argue that an organization would be more likely to respond to the demands of the organizations from which it obtains the critical resources required for survival than to demands from others present in the environment. For the Department of Health and Human Services (DHHS), critical resources, in the form of funding, are obtained from the Congress. This prediction is consistent with the actions of the Health Care Financing Administration (HCFA) in the construction of the proposed rule.

A common theme throughout the debate over the contents of the proposed rule was the position adopted by the Health Care Financing Administration (HCFA) that it was operating under the most correct interpretation of the congressional physician payment reform mandates. One explanation for the unresponsiveness of the Health Care Financing Administration (HCFA) to alternative interpretations that were presented by organizations in the environment is offered by resource dependency theory. Specifically, the early behavior of the Health Care Financing Administration (HCFA) in responding only to legislative direction implies that in its enacted environment, power over reform was perceived as resting exclusively with the Congress. This behavior is consistent with the rationality of resource

dependency in that by satisfying Congress, the Health Care Financing Administration (HCFA) was positively influencing the inflow of future funding. However, the organizational dynamics associated with the debate over the contents of the Notice of Proposed Rule Making (NPRM) suggest that the Health Care Financing Administration's (HCFA) enacted environment did not include the ability of other organizations in the environment to successfully influence Congress.

In particular, by not effectively managing the demands made through the other environmental linkages depicted in Figures 28 and 29, the Department of Health and Human Services (DHHS) encouraged the special interest groups to adapt. The health care related literature indicates that the adaptation of organizations of physicians took the form of identifying alternative means for influencing the development of physician payment reform policy. The emergent strategy of the organizations in the environment suggests an awareness of the value placed on the congressional linkage by the Department of Health and Human Services (DHHS). Furthermore, as discussed in Chapter IV, organizations present in environment also appeared to recognize the influence of the Physician Payment Review Commission (PPRC) on congressional payment reform policy. As a result of the active lobbying of organizations such as the American Medical Association (AMA) with Congress and the Physician Payment Review Commission (PPRC), special interest groups were able to gain the support of the majority of Congress including such influential members as Representative Stark, Subcommittee Chairman of the Ways and Means Subcommittee on Health and Senator Majority Leader Mitchell.

Resource dependency theory suggests that had this contingency been allowed for by the Health Care Financing Administration (HCFA), it would have adapted in a manner that would have allowed it to protect its linkage with Congress. The Health Care Financing Administration (HCFA) might have adapted by reevaluating its relationship with organizations such as the American Medical Association (AMA) and resolving differences in the interpretations over the requirements of the reform.

The health care related literature indicates that the Health Care Financing Administration (HCFA) remained unresponsive to the concerns of organizations in the environment until the threat of legislative action directing changes to the proposed rule emerged in Congress. The actions of the Health Care Financing Administration (HCFA) that followed can be explained from the perspective of resource dependency. Specifically, the proposed legislation and other indications of congressional support informally communicated demands by Congress that the Health Care Financing Administration (HCFA) reevaluate the interpretation of the requirements of reform communicated in the proposed rule. In turn, the Health Care Financing Administration (HCFA), aware that: a) all critical resources were obtained from Congress, b) that Congress had total discretion over funding allocation and appropriation, and c) that there were no alternatives for obtaining critical funding responded through adaptation by seeking the compromises described in the institutional portion of this analysis.

3. Organizational Performance

From the resource dependency perspective, one of the most prominent indicators of the success of the Health Care Financing Administration (HCFA) in accommodating the informal congressional demands was that formal legislative direction regarding the proposed rule was never realized. In this context it is apparent that Congress, as a client of the Health Care Financing Administration (HCFA), was satisfied with the revision in the Health Care Financing Administration's (HCFA) interpretation and that additional direction was not required in order for payment reform to be implemented as intended.

Finally, as discussed in previous chapters and in the institutional portion of this analysis, the special interest groups also appeared to have been satisfied by the compromises and promises offered by the Health Care Financing Administration (HCFA). Satisfaction on the part of the environment is embodied in the American Medical Association's (AMA) statement that it was time to call off the war with the Health Care Financing Administration (HCFA) and that legislative assistance in resolving differences over the proposed rule was no longer necessary. (Medicine and Health, 1992, [no page no. provided])

Institutional and resource dependency theories have enhanced the understanding of the Medicare Fee Schedule (MFS), its evolution, and its implementation. Although no single theory may be employed to gain a comprehensive understanding of the behavior of an organization, institutional and resource dependency have offered insight into factors that influenced the Department of Health and Human Services (DHHS) in the implementation of physician payment reform.

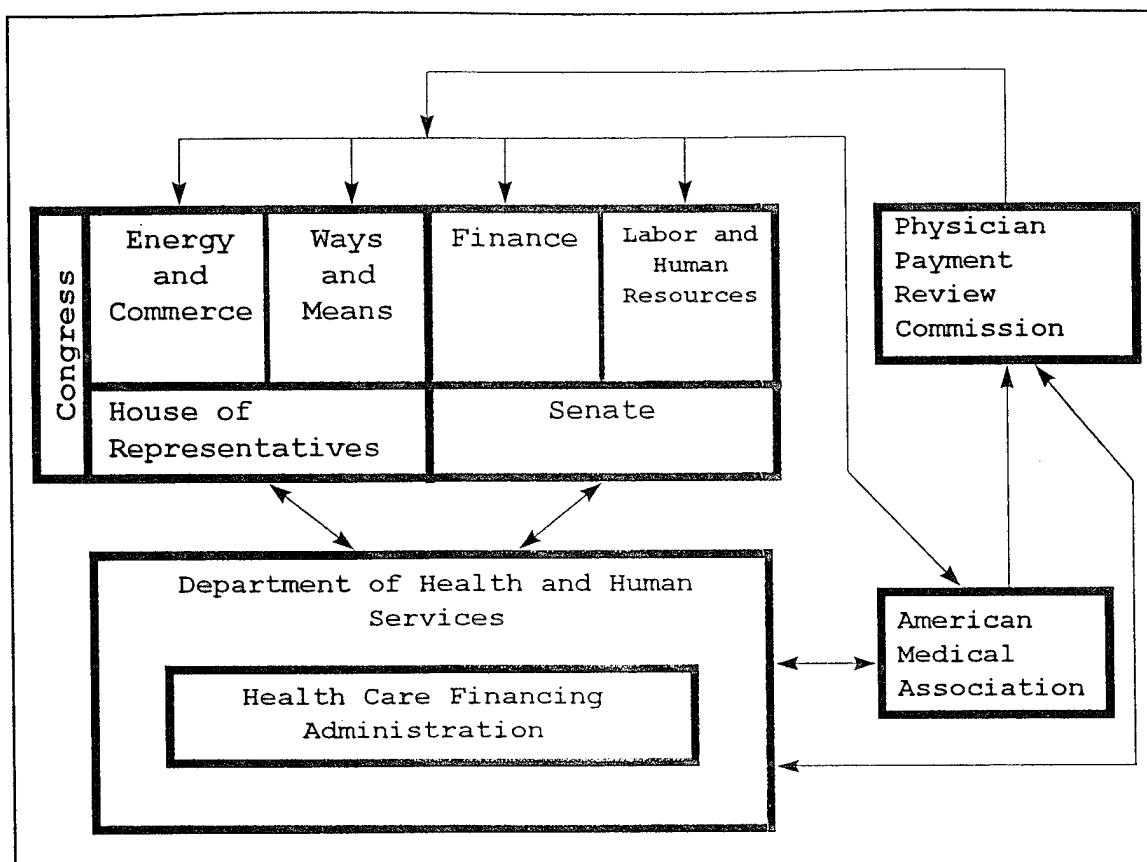


Figure 29. Department of Health and Human Services (DHHS) Selected Environmental Linkages.

VI. SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

A. SUMMARY

The purpose of this work was to gain an understanding of the formation and implementation of the objectives and incentives of the Medicare Fee Schedule (MFS) as set forth in the Omnibus Budget Reconciliation Acts (OBRA's) of 1989 and 1990. The tools used to facilitate this examination were drawn from the resource dependency and institutional theories. Specific objectives of the analysis were to:

- Establish the context under which physician payment reform was conceived and its implementation formally mandated.
- Identify and describe the administrative control systems that comprised physician payment reform, their objectives and salient interrelationships.
- Identify prominent organizations that exist in the Department of Health and Human Services (DHHS) organizational environment. Establish a broad understanding of the nature of the relationships between the Department and its environment.
- Examine the formation and implementation of the Medicare Fee Schedule (MFS) through application of the resource dependency and institutional theories. Use the Department of Health and Human Services (DHHS) as the focal organization for the analysis.

Chapter I provided a discussion of financial and demographic factors that influenced key decision makers in their consideration of the need for physician payment reform. The chapter began by describing major Medicare component programs, with emphasis on Medicare Part B, the component most affected by payment reform. Next, the pre-reform

environment was considered from the perspective of the objectives and incentives provided by the Customary, Prevailing and Reasonable (CPR) payment methodology. Finally, factors external to the Medicare program that were influencing the cost of physician care were considered.

Chapter II began with a brief description of the mechanics of the Current, Prevailing and Reasonable (CPR) methodology. Concepts and terminology that applied to both the pre- and post-payment reform environment were introduced and described. Next, the major payment reform mechanisms required by the Omnibus Budget Reconciliation Acts (OBRA's) of 1989 and 1990 were introduced, their objectives identified and their interrelationships delineated.

In Chapter II, emphasis was placed on the major programs that comprise the Medicare Fee Schedule (MFS). Specifically, the development and purpose of the Conversion Factor (CF), the Relative Value Scale (RVS), and the Geographic Adjustment Factors (GAF) were addressed.

The final section of Chapter II included a detailed quantitative discussion of the manner in which the Medicare Fee Schedule (MFS) would be used to identify post-reform allowable charges for a given procedure. Additionally, the Medicare Volume Performance Standard (MVPS) and the Maximum Allowable Actual Charge (MAAC) were presented on a qualitative as well as quantitative basis.

Chapter III introduced the resource dependency and institution theories which were used to analyze the Medicare Fee Schedule (MFS). Many of the primary components and

underlying principles associated with resource dependency and institutional theories were discussed as well as their similarities and differences.

In Chapter IV the Department of Health and Human Services (DHHS) was identified as the focal organization for the analysis. The general properties of its organizational environment were described. Specifically, the analysis proceeded by recognizing organizations that comprised the Health and Human Services (HHS) environment at the time of physician payment reform. Following the recognition and modeling of the Department of Health and Human Services (DHHS) environment, a chronology of physician payment reform was presented that emphasized the interaction between the Department and its environment during the development and implementation of the Medicare Fee Schedule (MFS).

The scope of this thesis and the large number of organizations present in the organizational environment precluded the inclusion of all organizations in the analysis. Consequently, a methodology was developed for identifying only those organizations that appeared to be most active in physician payment reform for use in the analysis. Once identified, the Department of Health and Human Services (DHHS) and the organizations active in its environment were modeled and considered within the context of resource dependency and institutional theory.

Chapter V contains the primary analysis of the Medicare Fee Schedule (MFS). In this chapter, issues associated with fee schedule formation and implementation are addressed. Specifically, the manner in which the Department of Health and Human Services (DHHS) interacted with the American Medical Association (AMA), the Physician Payment Review

Commission (PPRC), and Congress were considered from the perspectives suggested by the institutional and resource dependency theories.

B. CONCLUSIONS

As demonstrated in the previous chapters, factors having an impact on health care reform are numerous and complex. These factors comprise a spectrum that includes an aging population, rapid advances in technology, philosophical debate over health care as an entitlement and numerous other issues. For each of these issues the literature indicates that there are stakeholders actively competing to protect or acquire the scarce resources involved in the provision of health care. The research conducted in support of this analysis indicated that for nearly every component in the health care spectrum there was a corresponding special interest group or groups. As indicated in Chapter IV the interests represented by these groups were diverse and existed in a hyperpluralistic state prior to the introduction of the Notice of Proposed Rule Making (NPRM) by the Health Care Financing Administration (HCFA).

It is this spectrum of special interest groups that comprises the organizational environment for the Department of Health and Human Services (DHHS) both at the time of implementation of the Medicare Fee Schedule (MFS) and at the present. One of the single most impressive qualities of this environment was the degree to which it appeared to be fractured prior the publishing of the Notice of Proposed Rule Making (NPRM). The sector representing medical special interest groups provides an example of the depth of the

fracturing of the Department of Health and Human Services (DHHS) environment in two ways.

First, as illustrated in Chapter IV, the environmental complexity was illustrated in part by the sheer quantity of groups representing the interests of various physician specialties (e.g. American Medical Association (AMA), American Society of Internal Medicine (ASIM), American Academy of Family Physicians (AAFP), and American College of Cardiology (ACC)). Second, the environment was rendered more complex because of the potential for group members to pursue interests by holding memberships in multiple organizations. The number of possible combinations of individuals and organizations that results increases the potential number of unique positions that may be present in the environment. There are numerous examples in the literature of disagreements and dissension among organizations present in the environment and few examples of coalitions presenting a united position on payment reform before the Department of Health and Human Services (DHHS), Congress, or the Physician Payment Review Commission (PPRC). It appears that this property of the environment had an impact on the weight that the Department of Health and Human Services (DHHS) placed on its linkage to Congress relative to that which it had with other organizations.

The publishing of the Notice of Proposed Rule Making (NPRM) appears to have provided the stimulus needed to turn a fractured Department of Health and Human Services (DHHS) environment into one that was relatively united against the intended implementation of the rule. Furthermore, the inflexibility of the Department regarding other interpretations

of the congressional requirements for physician payment reform only served to increase the strength of opposition coalitions. As a result of being unable to engage in a dialog with the Department that might result in some form of compromise, it appears that organizations in the environment turned to other means of influencing the outcome of the reform, i.e., appeal to Congress.

Organizations, such as the American Medical Association (AMA), apparently concluded that their only opportunity for convincing the Department of Health and Human Services (DHHS) to revise the contents of the Notice of Proposed Rule Making (NPRM) prior to implementation was to win congressional support for the Association's positions. By winning congressional support, medical special interests were able to have an impact on the only linkage to which the Department was responding, that which existed with Congress.

The strategy that emerged for obtaining congressional support had two elements. The first element involved a direct lobbying effort between key members of the American Medical Association (AMA) and members of Congress. Though the lobbying effort contributed to the winning congressional support, it appears that it was the second strategic element that allowed for the support to be obtained in a relatively short period of time.

The second element of this strategy recognized the influence of the Physician Payment Review Commission (PPRC) on congressional health care policy. Members of Congress have openly admitted to their reliance on the Physician Payment Review Commission (PPRC) for guidance on health care reform issues. By winning support for their positions with the Physician Payment Review Commission (PPRC), in concert with their direct congressional

lobbying effort, the American Medical Association (AMA) was able to induce the Department of Health and Human Services (DHHS) for them to reevaluate many of the positions described in the Notice of Proposed Rule Making (NPRM).

The inflexibility that has been attributed to the Department of Health and Human Services (DHHS) in much of the literature does not appear to have been arbitrary or capricious. Instead, it appears that the Department was under significant pressure from Congress to implement physician payment reform relatively quickly. The complexity of the task, the need for legitimacy in its approach, the inherently political environment and the mandated two year period that existed from legislation to implementation left the Department of Health and Human Services (DHHS) with little flexibility for Department to deviate from its critical path. To generate a proposed rule that would find favor with the large number of diverse organizations in the Administration's environment was, in retrospect, an ambitious task. Still, what is remarkable is that the Department of Health and Human Services (DHHS) constructed a proposed rule that resulted in such broad opposition within a hyperpluralistic environment.

The absence of evidence that the Department sought clarification of the requirements of the Omnibus Budget Reconciliation Acts (OBRA) of 1989 and 1990 from Congress prior to issuing the proposed rule suggests one explanation for the generation of opposition to the Notice of Proposed Rule Making (NPRM). Instead of resolving uncertainty by consulting Congress, the Department remained committed to its interpretation of the congressional mandate while remaining relatively unresponsive to the opinions expressed by organizations

in the environment. An approach that might preclude similar occurrences for the Department in the future would be to more actively involve the writers of policy, members of Congress and their staff, in validating the Department's interpretation of a mandate prior to its implementation.

Finally, in researching this issue no instances of Department of Health and Human Services (DHHS) coalition building to support the proposed rule were encountered. Similarly, there is no evidence in the literature of a champion in Congress that defended the proposed implementation of the requirements of physician reform against critics. To the contrary, individuals that had a history of opposition to the agendas of organizations such as the American Medical Association (AMA), such as Representative Stark, were persuaded to join in opposition to the proposed rule. The Department may be able to avoid similar responses in the future by considering the potential impact of support or opposition by key decision makers during the development and implementation of proposed policy.

C. RECOMMENDATIONS FURTHER RESEARCH

Although the institutional and resource dependency theories provide useful insight into the manner in which physician payment reform was conceived and implemented, they do not provide a comprehensive picture of the reform. The following general topics may provide other avenues for gaining an understanding of physician payment reform:

- Using behavioral theories of organizations, describe the interaction between the Department of Health and Human Services (DHHS) and the Health Care Financing Administration (HCFA) during the period between the promulgation of the

Omnibus Budget Reconciliation Act (OBRA) of 1989 and the issuance of the Notice of Proposed Rule Making (NPRM).

- Using behavioral theories of organizations describe the interaction between the Congress and the Department of Health and Human Services during the period between the promulgation of the Omnibus Budget Reconciliation Act (OBRA) of 1989 and the issuance of the Notice of Proposed Rule Making (NPRM).
- Study the organization and composition of the Physician Payment Review Commission (PPRC). Model the manner in which the Commission receives and processes information. Consider the decision making processes that exist within the Commission and the manner in which it promulgates information to Congress and other relevant organizations.
- Model the relationship that exists between Congress and the Physician Payment Review Commission (PPRC) using the perspectives provided by organizational theory. Note the manner in which Congress provides the Commission with specific direction and the process by which the Commission satisfies tasking requirements.
- Study and identify the manner in which issues associated with physician payment reform were marked for consideration by congressional committees with jurisdiction over health care. Identify and consider from an organizational behavior perspective the manner in which payment reform information was gathered and decisions made.
- Consider from an organizational behavior perspective the formation of coalitions in opposition to the Notice of Proposed Rule Making (NPRM) that took place in the Department of Health and Human Services' (DHHS) environment.
- Select an organization from the Department of Health and Human Services' (DHHS) environment such as the American Medical Association or AFL-CIO. Construct a profile of the organization's formal positions on health care reform, beginning with the introduction of the Medicare program and extending through the implementation of physician payment reform. Consider the evolution of the organization's perspective on health care reform using an organizational theory perspective.
- Identify and analyze the methodology used by the Health Care Financing Administration (HCFA) to determine the values for the Conversion Factor (CF), the Relative Value Scale (RVS) and the Geographic Adjustment Factors (GAFs)

that were published in the Notice of Proposed Rule Making (NPRM). Consider the extent to which the use of assumptions and proxy data by the Health Care Financing Administration (HCFA) may have been influenced by the length of the implementation period.

- Differentiate physician payment reform actions mandated by the Omnibus Budget Reconciliation Acts (OBRA) of 1989 and 1990 from those for which the Health Care Financing Administration (HCFA) was given discretion. Using organizational behavior theory consider the congressional decision making process that determined the degree of latitude that was afforded the Health Care Financing Administration (HCFA) in the implementation of physician payment reform.

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APPENDIX. ENVIRONMENTAL ACTIVITY STATISTICS

Interest Group	Frequency	% of Total	Interest Group	Frequency	% of Total
American Academy of Family Physicians	20	1.37%	The Brookings Institution	1	0.07%
American Academy of Ophthalmology	1	0.07%	The Urban Institute	8	0.55%
American Academy of Pediatrics	3	0.20%	Health Industry Manufacturers Association	3	0.20%
American College of Cardiology	11	0.75%	Nonprescription Drug Manufacturers Association	2	0.14%
American College of Physicians	30	2.05%	Pharmaceutical Manufacturers Association	1	0.07%
American College of Radiology	7	0.48%	The Commonwealth Fund	4	0.27%
American College of Surgeons	13	0.89%	The Henry J. Kaiser Family Foundation	3	0.20%
American Medical Association	294	20.07%	The Robert Wood Johnson Foundation	2	0.14%
American Nurses Association	6	0.41%	AFL-CIO	22	1.50%
American Society of Anesthesiologists	1	0.07%	Business Roundtable	5	0.34%
American Society of Internal Medicine	46	3.14%	Council on Competitiveness	3	0.20%
Physicians for a National Health Program	2	0.14%	Chrysler Corporation	1	0.07%

Interest Group	Frequency	% of Total	Interest Group	Frequency	% of Total
American Hospital Association	45	3.07%	Health Care Equity Action League	2	0.14%
Catholic Health Association	1	0.07%	National Association of Manufacturers	24	1.64%
Federation of American Health Systems	2	0.14%	National Committee for Quality Health Care	1	0.07%
American Association of Retired Persons	30	2.05%	National Federation of Independent Business	5	0.34%
Citizen Action	4	0.27%	National Leadership Coalition for Health Care Reform	5	0.34%
Consumers Union	2	0.14%	National Small Business United	1	0.07%
Families USA	5	0.34%	Washington Business Group on Health	9	0.61%
Health Access	13	0.89%	General Accounting Office	18	1.23%
Public Citizen Health Research Group	1	0.07%	Census Bureau	3	0.20%
Health Insurance Association of America	21	1.43%	Office of Technology Assessment	4	0.27%
Blue Cross Blue Shield	2	0.14%	Congressional Budget Office	9	0.61%
American Managed Care and Review Association	1	0.07%	House Energy and Commerce Committee	5	0.34%

Interest Group	Frequency	% of Total	Interest Group	Frequency	% of Total
InterStudy	4	0.27%	House Committee on Ways and Means	80	5.46%
Group Health Association of America	2	0.14%	Senate Labor and Human Resources Committee	7	0.48%
Managed Health Care Association	3	0.20%	Senate Finance Committee	24	1.64%
National Committee for Quality Assurance	3	0.20%	Physician Payment Review Commission	108	7.37%
Employee Benefit Research Institute	4	0.27%	Democratic Party	38	2.59%
Heritage Foundation	5	0.34%	Republican Party	33	2.25%
National Center for Policy Analysis	2	0.14%	Department of Health and Human Services	127	8.67%
National Health Policy Forum	2	0.14%	Health Care Financing Administration	307	20.96%
Rand Corporation	11	0.75%	National Governor's Association	3	0.20%
Number of Hits by Column	597	40.75%		868	59.25%
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Table A1. Statistics Supporting the Approximation of Activity in the Physician Payment Reform Environment.

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